Landing Page

2018 Alternative Payment Models Survey

Overview

The Health Care Payment Learning and Action Network's (LAN) goal is to bring together private payers, providers, employers, state partners, consumer groups, individual consumers, and other stakeholders to accelerate the transition to alternative payment models (APMs).

To measure the nation's progress, the LAN launched the National APM Data Collection Effort in 2016. This workbook will be used to collect health plan data according to the Refreshed APM Framework, which was revised in January 2017, and line of business to be aggregated with other plan responses.

Contact Information

If you have any questions, please view the Frequently Asked Questions or email Andrea Caballero at acaballero@catalyze.org

Helpful Hover Over Definitions and Explanations

Throughout the assessment you will see text highlighted in blue. You may hover your cursor over the highlighted text to see further explanations or definitions that accompany the text. Feel free to hover your cursor over the example below.

Example Hover Over Text

Please Respond by July 31, 2018

General

Provide primary contact name, email and phone for the health plan respondent.

Your full name:	
Your work email address:	
Your work phone number:	

What is the total number of members covered by the health plan by line of business?

	Commercial	Medicare Advantage	Medicaid
Total number of members			

What is the plan's total health care spend (in- and out-of-network) by line of business?

	Commercial	Medicare Advantage	Medicaid
Total health care spend			

Reporting Period

Please specify if you are using CY 2017 data or most recent 12 months.

- ○ CY 2017 data
- ○ Most recent 12 months

Please specify the 12 month period.

	Month	Day	Year
Select Start Date:	▾	▾	▾

States

In which state(s) does the health plan have business?

	Commercial	Medicare Advantage	Medicaid
Alabama	☐	☐	☐
Alaska	☐	☐	☐
Arizona	☐	☐	☐
Arkansas	☐	☐	☐
California	☐	☐	☐
Colorado	☐	☐	☐
Connecticut	☐	☐	☐
Delaware	☐	☐	☐
District of Columbia	☐	☐	☐
Florida	☐	☐	☐
Georgia	☐	☐	☐
Hawaii	☐	☐	☐
Idaho	☐	☐	☐
Illinois	☐	☐	☐
Indiana	☐	☐	☐
Iowa	☐	☐	☐
Kansas	☐	☐	☐
Kentucky	☐	☐	☐
Louisiana	☐	☐	☐
Maine	☐	☐	☐
Maryland	☐	☐	☐
Massachusetts	☐	☐	☐
Michigan	☐	☐	☐
Minnesota	☐	☐	☐
Mississippi	☐	☐	☐
Missouri	☐	☐	☐
Montana	☐	☐	☐
Nebraska	☐	☐	☐

	Commercial	Medicare Advantage	Medicaid
Nevada	☐	☐	☐
New Hampshire	☐	☐	☐
New Jersey	☐	☐	☐
New Mexico	☐	☐	☐
New York	☐	☐	☐
North Carolina	☐	☐	☐
North Dakota	☐	☐	☐
Ohio	☐	☐	☐
Oklahoma	☐	☐	☐
Oregon	☐	☐	☐
Pennsylvania	☐	☐	☐
Rhode Island	☐	☐	☐
South Carolina	☐	☐	☐
South Dakota	☐	☐	☐
Tennessee	☐	☐	☐
Texas	☐	☐	☐
Utah	☐	☐	☐
Vermont	☐	☐	☐
Virginia	☐	☐	☐
Washington	☐	☐	☐
West Virginia	☐	☐	☐
Wisconsin	☐	☐	☐
Wyoming	☐	☐	☐
U.S. Territories	☐	☐	☐

Pharmacy Benefit

Does your submission include prescription drug claims data under the pharmacy benefit in the denominator (total spend)?

- ○ Yes
- ○ No

What percent of the pharmacy benefit spend is included?

	Commercial (percent)	Medicare Advantage (percent)	Medicaid (percent)	Unable to Answer (click here if you are unable to provide an answer)
Pharmacy benefit spend				☐

Behavioral Health

Does your submission include behavioral health claims data in the denominator (total spend)?

- ○ Yes
- ○ No

What percent of the behavioral health spend is included?

	Commercial (percent)	Medicare Advantage (percent)	Medicaid (percent)	Unable to Answer (click here if you are unable to provide an answer)
Behavioral health spend				☐

APM Instructions

Instructions

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2017 or most recent 12 months, as specified.

The goal is NOT to gather information on a projection or estimation of where the plan would be if their contracts were in place the entire calendar year. Rather it is based on what the plan actually paid in claims for the specified time period.

Methods

The metrics should report actual dollars paid through APMs CY 2017 or during the specified time period. For example, if a provider is paid $120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2017, the payments the provider received from January 1, 2017 through June 31, 2017 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2017 through December 31, 2017 ($60,000) would be reported as shared savings, if the reporting period is for CY 2017. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g., on a single day such as December 31, 2017, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received $300 (a combination of $285 base payment plus $15 in shared savings), which, if multiplied by 365 (annualized), would be reported as $109,500 in shared savings CY 2017. An unacceptable approach is counting all of the dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting $120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

Plans should report the total dollars paid, which includes the base payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc.

To the extent payment to a provider includes multiple APMs, the plans should put the dollars in the dominant APM, meaning the most advanced method. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

Metrics

Please note that the dollars paid through the various APMs are actual dollars paid to providers CY 2017 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on members attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

Alternative Payment Model Framework -Total Dollars

Total Dollars Paid to Providers in CY 2017 or most recent 12 months.

	Commercial	Medicare Advantage	Medicaid
Total dollars paid to providers (in and out of network) for members			

Was any portion of total dollars paid to providers in CY 2017 or most recent 12 months processed through alternative payment models?

- ○ Yes, we used alternative payment models for some payment
- ○ No, 100% of payments were APM Framework Category 1 (fee-for-service, DRGs or per diems)

Alternative Payment Model Framework - Category 1

Alternative Payment Model Framework - Category 1
(Metrics below apply to total dollars paid for members in CY 2017 or most recent 12 months. Metrics are NOT linked to quality)

Total dollars paid to providers through:

	Commercial	Medicare Advantage	Medicaid
Legacy payments			

Alternative Payment Model Framework -Category 2

Alternative Payment Model Framework - Category 2
(Metrics below apply to total dollars paid for members in CY 2017 or most recent 12 months. Metrics are linked to quality)

Total dollars paid to providers through:

	Commercial	Medicare Advantage	Medicaid
Foundational spending to improve care			
Fee-for-service plus pay-for-performance payments			

Alternative Payment Model Framework - Category 3

Alternative Payment Model Framework - Category 3

(Metrics below apply to total dollars paid for members in CY 2017 or most recent 12 months. Metrics are linked to quality)

Total dollars paid to providers through:

	Commercial	Medicare Advantage	Medicaid
Traditional shared-savings			
Utilization-based shared-savings			
Fee-for-service-based shared-risk			

	Commercial	Medicare Advantage	Medicaid
Procedure-based bundled/episode payments			
Population-based payments that are NOT condition-specific			

Alternative Payment Model Framework - Category 4

Alternative Payment Model Framework - Category 4
(Metrics below apply to total dollars paid for members in CY 2017 or most recent 12 months. Metrics are linked to quality)

Total dollars paid to providers through:

	Commercial	Medicare Advantage	Medicaid
Condition-specific, population-based payments			
Condition-specific bundled/episode payments			
Full or percent of premium population-based payments			
Integrated finance and delivery programs			

Cross-check: Models

What payment models were in effect during specified the period of reporting?

	Commercial	Medicare Advantage	Medicaid
Foundational spending to improve care	☐	☐	☐
Fee-for-service plus pay-for-performance	☐	☐	☐

	Commercial	Medicare Advantage	Medicaid
Traditional shared-savings	☐	☐	☐
Utilization-based shared-savings	☐	☐	☐
Fee-for-service-based shared-risk	☐	☐	☐
Procedure-based bundled/episode payments	☐	☐	☐
Population-based payments that are NOT condition-specific	☐	☐	☐
Condition-specific, population-based payments	☐	☐	☐
Condition-specific bundled/episode payments	☐	☐	☐
Full or percent of premium population-based payments	☐	☐	☐
Integrated finance and delivery programs	☐	☐	☐

Cross-check: Dates

For each program identified in the prior question, indicate when the program was launched.

	Commercial	Medicare Advantage	Medicaid
Foundational spending to improve care			

	Commercial	Medicare Advantage	Medicaid
Fee-for-service plus pay-for-performance			

performance

Traditional shared-savings			
Utilization-based shared-savings			
Fee-for-service-based shared-risk			
Procedure-based bundled/episode payments			
Population-based payments that are NOT condition-specific			
Condition-specific, population-based payments			
Condition-specific bundled/episode payments			
Full or percent of premium population-based payments			
Integrated finance and delivery programs			

Cross-check: Development Stage

For each program identified in the prior question, identify its current stage of implementation (Pilot, Expansion, Fully Implemented)

	Commercial	Medicare Advantage	Medicaid
Foundational spending to improve care			

	Commercial	Medicare Advantage	Medicaid
Fee-for-service plus pay-for-performance			

performance

Traditional shared-savings			
Utilization-based shared-savings			
Fee-for-service-based shared-risk			
Procedure-based bundled/episode payments			
Population-based payments that are NOT condition-specific			
Condition-specific, population-based payments			
Condition-specific bundled/episode payments			
Full or percent of premium population-based payments			
Integrated finance and delivery programs			

Cross-check: Integrated System

If dollars are paid to providers through integrated finance and delivery programs in CY 2017, please identify the payment method(s) used to pay providers under this arrangement.

	Commercial	Medicare Advantage	Medicaid
Foundational spending to improve care	☐	☐	☐
Fee-for-service plus pay-for-performance	☐	☐	☐

	Commercial	Medicare Advantage	Medicaid
Traditional shared-savings	☐	☐	☐
Utilization-based shared-savings	☐	☐	☐
Fee-for-service-based shared-risk	☐	☐	☐
Procedure-based bundled/episode payments	☐	☐	☐
Population-based payments that are NOT condition-specific	☐	☐	☐
Condition-specific, population-based payments	☐	☐	☐
Condition-specific bundled/episode payments	☐	☐	☐
Full or percent of premium population-based payments	☐	☐	☐
Integrated finance and delivery programs	☐	☐	☐

APM Trends

From health plan's perspective, what do you think will be the trend in APMs over the next 24 months?

- ○ APM activity will increase
- ○ APM activity will stay the same
- ○ APM activity will decrease
- ○ Not sure

Which APM subcategory do you think will be most impacted?

- ○ Traditional shared-savings, Utilization-based shared-savings (3A)
- ○ Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B)
- ○ Condition-specific, population-based payments, Condition-specific bundled/episode payments (4A)
- ○ Full or percent of premium population-based payments (4B)
- ○ Integrated finance and delivery programs (4C)
- ○ Not sure

APM Barriers

From health plan's perspective, what are the top barriers to APM adoption? (Select up to 3)

- ☐ Provider interest / readiness
- ☐ Health system interest / readiness
- ☐ Purchaser interest / readiness
- ☐ Government influence
- ☐ Ability to operationalize
- ☐ Willingness to take on financial risk
- ☐ Potential financial impact
- ☐ Market factors
- ☐ Other (please list)

From health plan's perspective, what are the top facilitators of APM adoption? (Select up to 3)

- ☐ Provider interest / readiness
- ☐ Health system interest / readiness
- ☐ Purchaser interest / readiness
- ☐ Government influence

- [ ] Ability to operationalize
- [ ] Willingness to take on financial risk
- [ ] Potential financial impact
- [ ] Market factors
- [ ] Other (please list)

APM Outcomes

From health plan's perspective, please indicate to what extent you agree or disagree that APM adoption will result in each of the following outcomes

	Strongly disagree	Disagree	Agree	Strongly agree	Not Sure
Better quality care	O	O	O	O	O
More affordable care	O	O	O	O	O
Improved care coordination	O	O	O	O	O
More consolidation among health care providers	O	O	O	O	O
Higher unit prices	O	O	O	O	O
Other (please list)	O	O	O	O	O

Assumptions

Please list other assumptions, qualifications, considerations, or limitations related to the data submission.

How many hours did it take your organization to complete this survey by line of business? Please report your response in hours.

	Commercial	Medicare Advantage	Medicaid
Hours to complete			

End

Congratulations! You have finished the survey. If you are ready to submit your responses and exit the survey, please click the "Submit" button. If you wish to review your responses, you may use the back button below or the table of content menu in top left corner.

Powered by Qualtrics

Definitions

Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods that use financial incentives to promote or leverage greater value - including higher quality care at lower costs - for patients, purchasers, payers and providers. This definition is specific to this exercise. If you are interested in MACRA's definition, please reference MACRA for more details. Refreshed APM Framework White Paper MACRA Website
Appropriate care measures	Appropriate care measures are metrics that are based on evidence based guidelines and comparative effective research. Such measures assess how well providers avoid unnecessarily costly, harmful, and unnecessary procedures. These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g. Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to: unnecessary –readmissions, preventable admissions, unnecessary imaging, appropriate medication use. Measures of appropriate care are required in order for a payment method to qualify as a Category 3 or 4 APM to ensure providers are incentivized to reduce/eliminate care that is wasteful and potentially harmful to patients. Appropriate care measures also ensure providers do not withhold necessary care and are incentivized to provide necessary care.
Category 1	Fee-for-service with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis

	related groups (DRGs) that are not linked to quality and value are classified in Category 1.
Category 2	Fee-for-service linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.
Category 3	Alternative payment methods (APMs) built on fee-for-service architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers that who meet their quality, and cost or utilization targets are eligible to share in savings, and those who do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. See definition of "appropriate care measures" for a description and examples.
Category 4	Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery

	systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants.
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A]**
Conditions-specific population-based payment	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. [APM Framework Category **4A**].
CY 2017 or most recent 12 months	Calendar year 2017 or the most current 12-month period for which the health plan can report payment information. This is the 12 month reporting period for which the health plan should report all of its "actual" spend data - a retrospective "look back."
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories

	and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**]
Foundational spending	Includes but is not limited to payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category **2A**]
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B]**
Integrated finance and delivery payments	Payments in which the delivery system is integrated with the finance system and delivers comprehensive care. These integrated arrangements consist of either insurance companies that own provider networks, or delivery systems that offer their own insurance products. The finance and delivery arms work in tandem to ensure that effective delivery investments are being made and that incentives and strategies within the organization are properly aligned.
Legacy payments	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs) and per diems. [APM Framework Category **1**].

Linked to quality	Payments that are set or adjusted based on evidence that providers meet quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet a threshold on cost and quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality" in Category 2. In order to qualify as a Category 3 or 4 APM, the link to quality must include "appropriate care measures." See definition of "appropriate care measures" for a description and examples.
Pay-for-performance	The use of incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. [APM Framework Categories **2C**].
Population-based payments that are NOT condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B**].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
Provider	For the purposes of this workbook, provider includes all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible, and excludes dental and vision.

Shared-risk	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
Total dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in calendar year (CY) 2017 or most recent 12 months.
Traditional shared-savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a pre-established set target for spending, as long as they meet quality targets. Traditional shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
Utilization-based shared-savings	A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g. Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to: emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets.