LAN 2020 APM Survey

Start of Block: Landing Page

2020 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 and state Medicaid agency data according to the Refreshed APM Framework and by 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 Andréa 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 24, 2020

End of Block: Landing Page

Start of Block: General

Provide organization name, primary contact name, email and phone for the payer respondent.

- Name of organization: _____
- Your full name: _____
- Your work email address: _____
- Your work phone number: _____

Please select the lines of business in which your organization operated in Calendar Year (CY) 2019. (Select all that apply)

- [ ] Commercial
- [ ] Medicare Advantage
- [ ] Medicaid

What was the total number of members covered by the payer by line of business in CY 2019?

	Commercial	Medicare Advantage	Medicaid
Total number of members			

What was the payer's total health care spend (in- and out-of-network) by line of business in CY 2019?

	Commercial	Medicare Advantage	Medicaid
⊗ Total health care spend			

End of Block: General

Start of Block: APM Instructions

Instructions

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment models (APMs) in calendar year (CY) 2019 or most recent 12 months for which data are available. The goal is NOT to gather information on a projection or estimation of where the payer would be if their contracts were in place the entire calendar year. Rather it is based on what the payer actually paid in claims for the specified time period.

Methods Payers 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 payers 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 3A).

For more information, please see the Frequently Asked Questions or email Andréa Caballero at acaballero@catalyze.org

Metrics Please note that the dollars paid through the various APMs are actual dollars paid to providers in CY 2019 or most recent 12 months. The dollars reported for each payment model serve as numerators to track the percentage of total dollars (the denominator) across the different APM subcategories. 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.

End of Block: APM Instructions

Start of Block: APM Models In Effect

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

	Commercial	Medicare Advantage	Medicaid
Legacy Payments	☐	☐	☐
Foundational spending to improve care	☐	☐	☐
Fee-for-service plus pay-for-performance	☐	☐	☐
Traditional shared savings	☐	☐	☐
Utilization-based shared savings	☐	☐	☐
Fee-for-service-based shared risk	☐	☐	☐
Procedure-based bundled/episode payments	☐	☐	☐
Condition-specific, population-based payments	☐	☐	☐
Condition-specific bundled/episode payments	☐	☐	☐
Population-based payments that are NOT condition-specific	☐	☐	☐
Full or percent of premium population-based payments	☐	☐	☐
Integrated finance and delivery programs	☐	☐	☐

Commercial Line of Business
Please list the total dollars paid through each of the payment models that were in effect in your organization's commercial line of business in 2019.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.
Legacy Payments : _____
Foundational spending to improve care : _____
Fee-for-service plus pay-for-performance : _____
Traditional shared savings : _____
Utilization-based shared savings : _____
Fee-for-service-based shared risk : _____
Procedure-based bundled/episode payments : _____
Condition-specific, population-based payments : _____
Condition-specific bundled/episode payments : _____
Population-based payments that are NOT condition-specific : _____
Full or percent of premium population-based payments : _____
Integrated finance and delivery programs : _____
Total : _____

Medicare Advantage Line of Business

Please list the total dollars paid through each of the payment models that were in effect in 2019 in your organization's Medicare Advantage line of business.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be

some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.
Legacy Payments: _____
Foundational spending to improve care: _____
Fee-for-service plus pay-for-performance: _____
Traditional shared savings: _____
Utilization-based shared savings: _____
Fee-for-service-based shared risk: _____
Procedure-based bundled/episode payments: _____
Condition-specific, population-based payments: _____
Condition-specific bundled/episode payments: _____
Population-based payments that are NOT condition-specific: _____
Full or percent of premium population-based payments: _____
Integrated finance and delivery programs: _____
Total (Auto Sum): _____

Medicaid Line of Business

Please list the total dollars paid through each of the payment models that were in effect in 2019 in your organization's Medicaid line of business.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.
Legacy Payments: _____
Foundational spending to improve care: _____
Fee-for-service plus pay-for-performance: _____
Traditional shared savings: _____
Utilization-based shared savings: _____
Fee-for-service-based shared risk: _____
Procedure-based bundled/episode payments: _____
Condition-specific, population-based payments: _____
Condition-specific bundled/episode payments: _____
Population-based payments that are NOT condition-specific: _____
Full or percent of premium population-based payments: _____
Integrated finance and delivery programs: _____
Total (Auto Sum): _____

End of Block: APM Models In Effect

Start of Block: Review Process

Please take a moment to review your data entry.

The sum of the dollars listed for each payment model (the numerators) should account for exactly 100% of the total dollars paid to providers in 2019 (the denominator). If the sum of the numerators does not equal the denominator, the LAN Measurement Team will email you to identify where dollars are missing or are double counted.

Commercial Line of Business

Total dollars reported for Commercial (denominator): ${Q5/ChoiceTextEntryValue/1/1}

Total dollars reported across the APMs in effect in the commercial market (sum of the numerators): ${Q8/TotalSum}

Medicare Advantage Line of Business

Total dollars reported for Medicare Advantage: ${Q5/ChoiceTextEntryValue/1/2}

Total dollars reported across the APMs in effect in the Medicare Advantage market (sum of the numerators): ${Q9/TotalSum}

Medicaid Line of Business

Total dollars reported for Medicaid (denominator): ${Q5/ChoiceTextEntryValue/1/3}

Total dollars reported across the APMs in effect in the Medicaid market (sum of the numerators): ${Q10/TotalSum}

For each line of business, is the denominator equal to the sum of the numerators?

- ○ Yes
- ○ No

Common issues for why the sum of the numerators is not equal to the denominator:

If the sum of the numerators is **greater than** the denominator:

Double counting of APM dollars: When a provider arrangement includes more than one type of payment method, all dollars flowing through that arrangement should be categorized today in the most advanced or "dominant" APM.

If the sum of the numerators is **less than** the denominator:

Not accounting for the underlying fee-for-service payments: Dollars categorized as an APM Categories 2 and 3 rely on a fee-for-service architecture. Payments classified as APMs should include the underlying fee-for-service payments in addition to any incentives, bonuses, or savings shared with the provider.

If you are able to resolve the issue, please use the back button to edit responses. If you have questions on how to categorize dollars, please contact Andréa Caballero at acaballero@catalyze.org.

End of Block: Review Process

Start of Block: Nominal Risk in Shared Risk Contracts

Understanding Nominal Risk in 3B FFS-Based Shared Risk Contracts

Instructions
Purpose = Track total dollars paid through FFS-based shared risk contracts that meet the threshold for the LAN's nominal risk specifications. The goal is NOT to gather competitively sensitive or contractual plan information.
Methods
Plans should report the dollars meeting the nominal risk threshold, and those that do not. The Worksheet tab within the LAN Nominal Risk Calculation Excel file is designed to help you discern which contracts meet the LAN's nominal risk threshold, and will aggregate dollars accordingly (see graphic below). Alternatively, if you know that 100% of your shared risk

contracts meet the LAN's nominal risk threshold, you can skip the worksheet and respond "yes" to the attestation below.

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

Please refer to the plan-level data as it appears in this section of the LAN Nominal Risk Calculation Worksheet

	MEETS LAN Nominal Risk Threshold		DOES NOT MEET LAN Nominal Risk Threshold		Total	
Line of Business	Dollars	% Total Spend	Dollars	% Total Spend	Dollars	% Total Spend
Commercial	$ -		$ -		$ -	
Medicare	$ -		$ -		$ -	
Medicaid	$ -		$ -		$ -	
Total	$ -		$ -		$ -	

For all lines of business in which your organization had dollars flowing through shared risk contracts in 2019, can you attest that 100% of those dollars meet the LAN nominal risk threshold?

- ○ Yes
- ○ No

What is the plan's total dollars flowing through shared risk contracts that MEET the LAN nominal risk threshold?

	Commercial	Medicare Advantage	Medicaid
⊗ Total dollars in shared risk contracts MEETING LAN nominal risk threshold			

What is the plan's total dollars flowing through shared risk contracts that DO NOT MEET the LAN nominal risk threshold?

	Commercial	Medicare Advantage	Medicaid
⊗ Total dollars in shared risk contracts NOT MEETING LAN nominal risk threshold			

End of Block: Nominal Risk in Shared Risk Contracts

Start of Block: APM Trends

Informational Questions

The following questions ask about the current and future state of payment reform from the health plan’s perspective.

For the purposes of this survey, health plan refers to any type of health insurance company, third party administrator, or health care purchaser paying for health care provisions on behalf of a population (e.g. state Medicaid agency).

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 increase the most in activity over the next 24 months?

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

Which APM subcategory do you think will decrease the most in activity over the next 24 months?

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

End of Block: APM Trends

Start of Block: APM Barriers and Facilitators

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

- [ ] Provider interest / readiness
- [ ] Health plan interest / readiness
- [ ] Purchaser interest / readiness
- [ ] Government influence
- [ ] Provider ability to operationalize
- [ ] Health plan ability to operationalize
- [ ] Interoperability
- [ ] Provider willingness to take on financial risk
- [ ] Market factors
- [ ] Other (please list) _____

*

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

- ☐ Provider interest / readiness
- ☐ Health plan interest / readiness
- ☐ Purchaser interest / readiness
- ☐ Government influence
- ☐ Provider ability to operationalize
- ☐ Health plan ability to operationalize
- ☐ Interoperability
- ☐ Provider willingness to take on financial risk
- ☐ Market factors
- ☐ Other (please list) _____

End of Block: APM Barriers and Facilitators

Start of Block: 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.

(Please respond to each statement listed)

	Strongly disagree	Disagree	Agree	Strongly agree	Not Sure
Better quality care	○	○	○	○	○
More affordable care	○	○	○	○	○
Improved care coordination	○	○	○	○	○
More consolidation among health care providers	○	○	○	○	○
Higher unit prices for discrete services	○	○	○	○	○

Given that your organization operated in more than one line of business in 2019, do the answers provided to the informational questions vary according to line of business?

- ○ Yes
- ○ No

Please describe how the answers vary by line of business.

_____

End of Block: APM Outcomes

Start of Block: Reporting burden

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 of Block: Reporting burden

Start of Block: 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 contents menu in top left corner.

End of Block: End