Landing Page

2019 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 caballero@catalyze.org

Helpful Hover Over Definitions and Explanations

Throughout this 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 26, 2019

General

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

Name of organization:

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 2018 data or most recent 12 months.

- ○ CY 2018 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?

State	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	☐	☐	☐
Nevada	☐	☐	☐
New Hampshire	☐	☐	☐
New Jersey	☐	☐	☐

State	Commercial	Medicare Advantage	Medicaid
New Mexico	☐	☐	☐
New York	☐	☐	☐
North Carolina	☐	☐	☐
North Carolina	☐	☐	☐
North Dakota	☐	☐	☐
Ohio	☐	☐	☐
Oklahoma	☐	☐	☐
Oregon	☐	☐	☐
Pennsylvania	☐	☐	☐
Rhode Island	☐	☐	☐
South Carolina	☐	☐	☐
South Dakota	☐	☐	☐
Tennessee	☐	☐	☐
Texas	☐	☐	☐
Utah	☐	☐	☐
Vermont	☐	☐	☐
Virginia	☐	☐	☐
Washington	☐	☐	☐
West Virginia	☐	☐	☐
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

Goal/purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2018 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

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).

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 2018 or most recent 12 months. 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 2018 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 2018 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

(Metrics below apply to total dollars paid for members in CY 2018 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

(Metrics below apply to total dollars paid for members in CY 2018 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

(Metrics below apply to total dollars paid for members in CY 2018 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			
Procedure-based bundled/episode payments			

Alternative Payment Model Framework – Category 4

(Metrics below apply to total dollars paid for members in CY 2018 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			

	Commercial	Medicare Advantage	Medicaid
Population-based payments that are NOT condition-specific			
Full or percent of premium population-based payments			
Integrated finance and delivery programs			

Integrated System Payment Methods

Please report how dollars flowing through integrated finance and delivery programs are spread across different payment methods used to pay providers. (The total for each market segment must sum to 100.)

Integrated Finance and Delivery Programs in COMMERCIAL Market:

If dollars are paid to providers through integrated finance and delivery programs in CY 2018 in the commercial market, please break down the percentage of those dollars flowing through each of the payment method(s) below.

Salary	
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	
Total	

Integrated Finance and Delivery Programs in MEDICARE ADVANTAGE Market:

If dollars are paid to providers through integrated finance and delivery programs in CY 2018 in the Medicare Advantage market, please break down the percentage of those dollars flowing through each of the payment method(s) below.

Salary	
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	
Total	

Integrated Finance and Delivery programs in MEDICAID Market:

If dollars are paid to providers through integrated finance and delivery programs in CY 2018 in the Medicaid market, please breakdown the percentage of those dollars flowing through each of the payment method(s) below.

Salary	
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	
Total	

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	☐	☐	☐
Traditional shared-savings	☐	☐	☐

	Commercial	Medicare Advantage	Medicaid
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	☐	☐	☐

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			
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			

	Commercial	Medicare Advantage	Medicaid
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			
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			

	Commercial	Medicare Advantage	Medicaid
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			

APM Trends

From the 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

[Display this question If "APM activity will increase" is selected] 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

[Display this question If "APM activity will decrease" is selected] 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

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
○ 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 of APM adoption? (Select up to 3)

- ○ Provider interest / readiness
- ○ Health system 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)

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	○	○	○	○	○
More affordable care	○	○	○	○	○
Improved care coordination	○	○	○	○	○
More consolidation among health care providers	○	○	○	○	○

	Strongly disagree	Disagree	Agree	Strongly agree	Not sure
Higher unit prices for discreet services	○	○	○	○	○
Other (please list)	○	○	○	○	○

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.
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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]**
Condition-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. See Frequently Asked Questions for more information. [APM Framework Category **4A**].
CY 2018 or most recent 12 months	Calendar year 2018 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 system 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, or payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships. See Frequently Asked Questions for more information. [APM Framework Category **4C**]
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.
Medicaid Market	For the purposes of this survey, the Medicaid market segment includes both business with a state to provide health benefits to Medicaid eligible individuals and state-run programs themselves. Data submitted for this survey should exclude the following: health care spending for dual-eligible beneficiaries, health care spending for long-term services and support (LTSS), spending for dental and vision services. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2018 or the most recent 12-month period for which data is available. See “General Information” tab in the Excel workbook for more information.
Medicare Advantage Market	For the purposes of this survey, the Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare

	Advantage plan has Part D or drug spending under its operations, it should include this information in its response. Responses to the survey will reflect dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2018 or the most recent 12-month period for which data is available. Dental and vision services are excluded.
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 cover primary, acute and post-acute care that is not specific to any particular condition. [APM Framework Category **4B**]

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) 2018 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.