LAN 2022 APM Survey

Start of Block: Landing Page

Q1 **2022 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. **Submission Guidance**There are three organizations collaborating on collecting APM data for the LAN's annual measurement effort. These organizations are Blue Cross Blue Shield Association (BCBSA), AHIP (formerly known as America's Health Insurance Plans), Association for Community Affiliated Plans (ACAP), and the Health Care Payment-Learning and Action Network (LAN). Your organization could be a member of more than one of these organizations and asked to submit data to one or more of these three entities. If your organization has questions as to which entity to submit data, please contact Andréa Caballero at acaballero@catalyze.org for guidance.

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 30, 2022**

End of Block: Landing Page

Start of Block: General

Q2 Provide organization name, primary contact name, email and phone for the payer respondent.

- ○ Name of organization: (4) _____
- ○ Your full name: (1) _____
- ○ Your work email address: (2) _____
- ○ Your work phone number: (3) _____

Q3 Please select the lines of business in which your organization operated in Calendar Year (CY) 2021. (Select all that apply)

- ☐ Commercial (1)
- ☐ Medicare Advantage (2)
- ☐ Medicaid (3)

Q4 What was the total number of members covered by the payer by line of business in CY 2021?

Display This Answer:

If LOB selection = Commercial

Display This Answer:

If LOB selection = Medicare Advantage

Display This Answer:

If LOB selection = Medicaid

	Display This Answer: If LOB selection = Commercial Commercial (1)	*Display This Answer: If LOB selection = Medicare Advantage* Medicare Advantage (2)	*Display This Answer: If LOB selection = Medicaid* Medicaid (3)
⊗ Total number of members (1)			

Q5 What was the payer's total health care spend (in- and out-of-network) by line of business in CY 2021?

Display This Answer:
If LOB selection = Commercial
Display This Answer:
If LOB selection = Medicare Advantage
Display This Answer:
If LOB selection = Medicaid

	Display This Answer: If LOB selection = Commercial Commercial (1)	*Display This Answer: If LOB selection = Medicare Advantage* Medicare Advantage (2)	*Display This Answer: If LOB selection = Medicaid* Medicaid (3)
⊗ Total health care spend (1)			

End of Block: General

Start of Block: APM Instructions

Q6 **Instructions**
Goal/Purpose = Track total dollars paid through legacy payments and alternative payment models (APMs) in calendar year (CY) 2021 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 (Pay-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 2021 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

Q7 What payment models were in effect during the specified period of reporting?

Display This Answer:

If LOB selection = Commercial

Display This Answer:

If LOB selection = Medicare Advantage

Display This Answer:

If LOB selection = Medicaid

	Display This Answer: If LOB selection = Commercial	*Display This Answer: If LOB selection = Medicare Advantage*	*Display This Answer: If LOB selection = Medicaid*
	Commercial (1)	Medicare Advantage (2)	Medicaid (3)
Legacy Payments (13)	☐	☐	☐
Foundational spending to improve care (1)	☐	☐	☐
Fee-for-service plus pay-for-performance (2)	☐	☐	☐
Traditional shared savings (3)	☐	☐	☐
Utilization-based shared savings (4)	☐	☐	☐
Fee-for-service-based shared risk (5)	☐	☐	☐
Procedure-based bundled/episode payments (6)	☐	☐	☐
Condition-specific, population-based payments (8)	☐	☐	☐
Condition-specific bundled/episode payments (9)	☐	☐	☐

Population-based payments that are NOT condition-specific (7)	☐	☐	☐
Full or percent of premium population-based payments (10)	☐	☐	☐
Integrated finance and delivery programs (11)	☐	☐	☐

Display This Question:

If LOB selection = Commercial

JS

Q8 **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 2021.

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.

Display This Choice:

If Payment Model Selection = Legacy Payments [Commercial]

Legacy Payments : _____ (13)

Display This Choice:

If Payment Model Selection = Foundational spending to improve care [Commercial]

Foundational spending to improve care : _____ (1)

Display This Choice:

If Payment Model Selection = Fee-for-service plus pay-for-performance [Commercial]

Fee-for-service plus pay-for-performance : _____ (2)

Display This Choice:

If Payment Model Selection = Traditional shared savings [Commercial]

Traditional shared savings : _____ (3)

Display This Choice:

If Payment Model Selection = Utilization-based shared savings [Commercial]

Utilization-based shared savings : _____ (4)

Display This Choice:

If Payment Model Selection = Fee-for-service-based shared risk [Commercial]

Fee-for-service-based shared risk : _____ (5)

Display This Choice:

If Payment Model Selection = Procedure-based bundled/episode payments [Commercial]

Procedure-based bundled/episode payments : _____ (6)

Display This Choice:

If Payment Model Selection = Condition-specific, population-based payments [Commercial]

Condition-specific, population-based payments : _____ (8)

Display This Choice:

If Payment Model Selection = Condition-specific bundled/episode payments [Commercial]

Condition-specific bundled/episode payments : _____ (9)

Display This Choice:

If Payment Model Selection = Population-based payments that are NOT condition-specific [Commercial]

Population-based payments that are NOT condition-specific : _____ (7)

Display This Choice:

If Payment Model Selection = Full or percent of premium population-based payments [Commercial]

Full or percent of premium population-based payments : _____ (10)

Display This Choice:

If Payment Model Selection = Integrated finance and delivery programs [Commercial]

Integrated finance and delivery programs : _____ (11)

Total : _____

Display This Question:

If LOB selection = Medicare Advantage

JS

Q9 **Medicare Advantage Line of Business**

Please list the total dollars paid through each of the payment models that were in effect in 2021 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.

Display This Choice:

If Payment Model Selection = Legacy Payments [Medicare Advantage]

Legacy Payments : _____ (13)

Display This Choice:

If Payment Model Selection = Foundational spending to improve care [Medicare Advantage]

Foundational spending to improve care : _____ (1)

Display This Choice:

If Payment Model Selection = Fee-for-service plus pay-for-performance [Medicare Advantage]

Fee-for-service plus pay-for-performance : _____ (2)

Display This Choice:

If Payment Model Selection = Traditional shared savings [Medicare Advantage]

Traditional shared savings : _____ (3)

Display This Choice:

If Payment Model Selection = Utilization-based shared savings [Medicare Advantage]

Utilization-based shared savings : _____ (4)

Display This Choice:

If Payment Model Selection = Fee-for-service-based shared risk [Medicare Advantage]

Fee-for-service-based shared risk : _____ (5)

Display This Choice:

If Payment Model Selection = Procedure-based bundled/episode payments [Medicare Advantage]

Procedure-based bundled/episode payments : _____ (6)

Display This Choice:

If Payment Model Selection = Condition-specific, population-based payments [Medicare Advantage]

Condition-specific, population-based payments : _____ (8)

Display This Choice:

If Payment Model Selection = Condition-specific bundled/episode payments [Medicare Advantage]

Condition-specific bundled/episode payments : _____ (9)

Display This Choice:

If Payment Model Selection = Population-based payments that are NOT condition-specific [Medicare Advantage]

Population-based payments that are NOT condition-specific : _____ (7)

Display This Choice:

If Payment Model Selection = Full or percent of premium population-based payments [Medicare Advantage]

Full or percent of premium population-based payments : _____ (10)

Display This Choice:

If Payment Model Selection = Integrated finance and delivery programs [Medicare Advantage]

Integrated finance and delivery programs : _____ (11)
Total : _____

Display This Question:

If LOB selection = Medicaid

JS

Q10 **Medicaid Line of Business**

Please list the total dollars paid through each of the payment models that were in effect in 2021 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.

Display This Choice:

If Payment Model Selection = Legacy Payments [Medicaid]

Legacy Payments : _____ (13)

Display This Choice:

If Payment Model Selection = Foundational spending to improve care [Medicaid]

Foundational spending to improve care : _____ (1)

Display This Choice:

If Payment Model Selection = Fee-for-service plus pay-for-performance [Medicaid]

Fee-for-service plus pay-for-performance : _____ (2)

Display This Choice:

If Payment Model Selection = Traditional shared savings [Medicaid]

Traditional shared savings : _____ (3)

Display This Choice:

If Payment Model Selection = Utilization-based shared savings [Medicaid]

Utilization-based shared savings : _____ (4)

Display This Choice:

If Payment Model Selection = Fee-for-service-based shared risk [Medicaid]

Fee-for-service-based shared risk : _____ (5)

Display This Choice:

If Payment Model Selection = Procedure-based bundled/episode payments [Medicaid]

Procedure-based bundled/episode payments : _____ (6)

Display This Choice:

If Payment Model Selection = Condition-specific, population-based payments [Medicaid]

Condition-specific, population-based payments : _____ (8)

Display This Choice:

If Payment Model Selection = Condition-specific bundled/episode payments [Medicaid]

Condition-specific bundled/episode payments : _____ (9)

Display This Choice:

If Payment Model Selection = Population-based payments that are NOT condition-specific [Medicaid]

Population-based payments that are NOT condition-specific : _____ (7)

Display This Choice:

If Payment Model Selection = Full or percent of premium population-based payments [Medicaid]

Full or percent of premium population-based payments : _____ (10)

Display This Choice:

If Payment Model Selection = Integrated finance and delivery programs [Medicaid]

Integrated finance and delivery programs : _____ (11)
Total : _____

End of Block: APM Models In Effect

Start of Block: Review Process

Q11 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 2021 (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.

Display This Question:

If LOB selection = Commercial

Q12
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}

Display This Question:

If LOB selection = Medicare Advantage

Q13 **Medicare Advantage Line of Business**

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

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

Display This Question:

If LOB selection = Medicaid

Q14 **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}

Q15 For each line of business, is the denominator equal to the sum of the numerators?

- ○ Yes (23)
- ○ No (24)

Display This Question:

If Y N Cross Check = No

Q16
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: APM Trends

Q17 **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).

Q18 From health plan's perspective, what do you think will be the trend in APMs over the next 24 months?

- APM activity will increase (1)
- APM activity will stay the same (2)
- APM activity will decrease (3)
- Not sure (4)

Display This Question:

If APM Trend Outlook = APM activity will increase

Q19 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) (1)
- Fee-for-service-based shared risk, Procedure-based bundled/episode payments (3B) (2)
- Condition-specific, population-based payments, Condition-specific bundled/episode payments (4A) (3)
- Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B) (4)
- Integrated finance and delivery programs (4C) (5)
- Not sure (6)

Display This Question:

If APM Trend Outlook = APM activity will decrease

Q20 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) (1)
- Fee-for-service-based shared risk, Procedure-based bundled/episode payments (3B) (2)
- Condition-specific, population-based payments, Condition-specific bundled/episode payments (4A) (3)
- Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B) (4)
- Integrated finance and delivery programs (4C) (5)
- Not sure (6)

End of Block: APM Trends

Start of Block: APM Barriers and Facilitators

Q21 From health plan’s perspective, what are the top barriers to APM adoption? (Select up to 3)

- [ ] Provider interest / readiness (1)
- [ ] Health plan interest / readiness (2)
- [ ] Purchaser interest / readiness (3)
- [ ] Government influence (4)
- [ ] Provider ability to operationalize (5)
- [ ] Health plan ability to operationalize (10)
- [ ] Interoperability (7)
- [ ] Provider willingness to take on financial risk (6)
- [ ] Market factors (8)
- [ ] Other (please list) (9) _____

Q22 From health plan’s perspective, what are the top facilitators to APM adoption? (Select up to 3)

- [ ] Provider interest / readiness (1)
- [ ] Health plan interest / readiness (2)
- [ ] Purchaser interest / readiness (3)
- [ ] Government influence (4)
- [ ] Provider ability to operationalize (5)
- [ ] Health plan ability to operationalize (10)
- [ ] Interoperability (7)
- [ ] Provider willingness to take on financial risk (6)
- [ ] Market factors (8)
- [ ] Other (please list) (9) _____

End of Block: APM Barriers and Facilitators

Start of Block: APM Outcomes

Q23 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 (45)	Disagree (46)	Agree (50)	Strongly agree (51)	Not Sure (48)
Better quality care (1)	○	○	○	○	○
More affordable care (2)	○	○	○	○	○
Improved care coordination (3)	○	○	○	○	○
More consolidation among health care providers (11)	○	○	○	○	○
Higher unit prices for discrete services (12)	○	○	○	○	○

End of Block: APM Outcomes

Start of Block: Health Equity

Q24 Is your Plan leveraging value-based provider arrangements to incentivize providers to improve health equity through the following strategies? Check all responses that apply.

- [ ] Collection of standardized race, ethnicity, and language data (1)
- [ ] Collection of sexual orientation, gender, and identity data (2)
- [ ] Collection of disability status (3)
- [ ] Collection of veteran status (4)
- [ ] Participation in implicit bias (or similar) training (5)
- [ ] Complete staff competencies to serve diverse populations (6)
- [ ] Reporting performance measures by race, ethnicity, and language (7)
- [ ] Measurement of clinical outcome inequities among member groups (8)
- [ ] Reduction of clinical outcome inequities among member groups (9)
- [ ] Participation in quality improvement collaboratives (10)
- [ ] Expanding access to virtual or digital care (13)
- [ ] If other, please specify (14) _____

Q25 If incentives are included in your value-based provider arrangements to improve Social Determinants of Health (SDoH), what specific SDoH or delivery strategies are intended to improve? Check all that apply.

- [ ] Screening for socioeconomic barriers known to impact health or health outcomes (1)
- [ ] Multidisciplinary team models (e.g. social worker, community health worker, medical staff, doulas, etc.) (2)
- [ ] Referrals to community-based organizations to address socioeconomic barriers (3)
- [ ] Verifications of interventions provided (4)
- [ ] Care coordination for services that address socioeconomic barriers (5)
- [ ] Food insecurity (e.g., offering resources for access to nutritious food) (6)
- [ ] Safe transportation (e.g., incentives or partnerships in ride sharing programs) (7)
- [ ] Housing insecurity (e.g., provider sponsored housing after a hospital discharge) (8)
- [ ] Economic insecurity (e.g., connections to job placement or training services) (9)
- [ ] Social isolation and loneliness (e.g., peer connection programs, group meetings, etc.) (10)
- [ ] Other basic needs (e.g., providing clothing, diapers, or gift cards; helping with utilities or childcare, etc.) (11)
- [ ] Expanding access to virtual or digital care (13)
- [ ] If other, please specify (14) _____

Q26 The Health Care Payment and Learning Action Network (HCP-LAN) is interested in learning first-hand from health plans about incentives to address health equity and multi-payer collaboration in APM design and implementation.

Is your organization willing to provide additional insights to the LAN about these topics if contacted?

- ○ Yes (1)
- ○ No (2)

Display This Question:

If If LOB selection q://QID46/SelectedChoicesCount Is Greater Than 1

Q27 Given that your organization operated in more than one line of business in 2021, do the answers provided to the informational questions vary according to line of business?

- ○ Yes (31)
- ○ No (32)

Display This Question:

If Info Questions Varying by LOB = Yes

Q28 Please describe how the answers vary by line of business.

_____

End of Block: Health Equity

Start of Block: Reporting burden

Q29 Please list other assumptions, qualifications, considerations, or limitations related to the data submission.

_____

_____

_____

Q30 How many hours did it take your organization to complete this survey by line of business? Please report your response in hours.

Display This Answer:

If LOB selection = Commercial

Display This Answer:

If LOB selection = Medicare Advantage

Display This Answer:

If LOB selection = Medicaid

	Display This Answer: If LOB selection = Commercial Commercial (1)	*Display This Answer: If LOB selection = Medicare Advantage* Medicare Advantage (2)	*Display This Answer: If LOB selection = Medicaid* Medicaid (3)
⊗ Hours to complete (1)			

End of Block: Reporting burden

Start of Block: Participation Recognition

Q31 My organization (health plan) or agency (state Medicaid agency) agrees to be publicly recognized as a data contributor to the annual measurement effort and the reported APM results. Only the name of the organization will be shared with the LAN and organization responses will remain de-identified.

- ○ Yes (1)
- ○ No (2)

End of Block: Participation Recognition

Start of Block: End

Q32 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
