# LAN 2023 APM Survey

Q1 **2023 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 online survey 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 four organizations collaborating on collecting APM data for the LAN's annual measurement effort. These organizations are Blue Cross Blue Shield Association (BCBSA), AHIP, 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 entities.
• If you are a LAN and AHIP member, please submit to AHIP.
• If you are an ACAP and an AHIP member, please submit to AHIP and please answer the survey question about whether we can share the data with ACAP.
• In the rare case that you are receiving this link and you are a member of BCBSA and an AHIP member, your BCBSA submission should suffice unless you have significant non-Blue branded business you would like to submit to AHIP to ensure it is also captured.

If your organization has questions as to which entity to submit data, please contact Andrea 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 31, 2023**

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)

_____

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Q3 Please select the lines of business in which your organization operated in Calendar Year (CY) 2022. (Select all that apply)

☐ Commercial  (1)

☐ Medicare Advantage  (2)

☐ Medicaid  (3)

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Q4 What was the total number of members covered by the payer by line of business in CY 2022?

| | Commercial (1) | Medicare Advantage (2) | Medicaid (3) |
|---|---|---|---|
| *Display This Answer:* | *If LOB selection = Commercial* | *If LOB selection = Medicare Advantage* | *If LOB selection = Medicaid* |
| ⊗ 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 2022?

| | Display This Answer:<br>If LOB selection = Commercial<br><br>Commercial (1) | Display This Answer:<br>If LOB selection = Medicare Advantage<br><br>Medicare Advantage (2) | Display This Answer:<br>If LOB selection = Medicaid<br><br>Medicaid (3) |
|---|---|---|---|
| ⊗ Total health care spend (1) | | | |

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

**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) 2022 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](mailto:acaballero@catalyze.org)

**Metrics**

Please note that the dollars paid through the various APMs are actual dollars paid to providers in CY 2022 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?

| | Commercial (1) | Medicare Advantage (2) | Medicaid (3) |
|---|---|---|---|
| | *Display This Answer: If LOB selection = Commercial* | *Display This Answer: If LOB selection = Medicare Advantage* | *Display This Answer: If LOB selection = Medicaid* |
| 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) | ☐ | ☐ | ☐ |

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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 2022.

 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:* |

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

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

Integrated finance and delivery programs : _____  (11)

Total : _____

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JS

## Q9 **Medicare Advantage Line of Business**

Please list the total dollars paid through each of the payment models that were in effect in 2022 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)

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

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

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

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JS

Q10 **Medicaid Line of Business**

Please list the total dollars paid through each of the payment models that were in effect in 2022 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)

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

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

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 2022 (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.

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}

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}

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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}

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

○ Yes  (23)

○ No  (24)

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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.

Q17 **Instructions: Measuring Lives in Accountable Care APMs**
Goal/Purpose = To measure the percentage of plan members in accountable care APMs in CY 2022 or most recent 12 months, as specified.

**Methods**

The information for these questions will be used to report the percentage of plan members attributed, aligned, assigned, or empaneled to a primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in a total cost of care (TCOC) accountable care  APM of six months or longer in CY 2022 or most recent 12 months.

Plans should use the general guidance below to allocate members to the accountable care APM covered lives questions.

**General Guidance on Allocating Health Plan Members to the Accountable Care APM Questions:**
Health plans typically attribute health plan members in accountable care APM arrangements to a PCP/PCG. In some situations, health plans/states may attribute members to **both** a PCP/PCG and a non-PCP (i.e., specialist). In these instances, for the following questions **health plans should attribute members to either the PCP/PCG or the non-PCP focused accountable care APM questions but not both.**

If your organization attributes members to only the PCP/PCG accountable care APMs, the following applies:

**1. Allocating health plan member lives to Category 3A and/or Category 3B accountable care APM arrangements**
If your organization attributes health plan members to the PCP/PCG focused accountable care APM questions, please attribute your organization's covered lives to Category 3A, Category 3B, or both (i.e., 3A and 3B).

**2. Allocating health plan member lives to Category 4 (i.e., all of Category 4 combined) accountable care APM arrangements**
If your organization has covered lives in any of Category 4 (i.e., 4A, 4B, 4C), the LAN assumes all of those covered lives are in a TCOC accountable care APM, and therefore should be counted and captured in the Category 4 accountable care APM question.

If your organization attributes members to only the non-PCP (i.e., specialist) accountable care APMs, the following applies:

**1. Allocating health plan member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements**
If your organization attributes members to non-PCP (i.e., specialist) focused accountable care arrangements, please attribute your organization's member lives to any of Category 3 (i.e., 3A and 3B combined) and/or any of Category 4 (i.e., 4A, 4B, 4C).

For further guidance, please reference this document for additional definitional parameters along with inclusion/exclusion criteria. This provides examples that will help with answering the accountable care questions.

**End of Block: Measuring Lives in Accountable Care APMs Instructions**

**Start of Block: Accountable Care APM Selection**

*Display This Question:*

> *If Payment Model Selection = Traditional shared savings [ Commercial ]*
>
> *Or Payment Model Selection = Traditional shared savings [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Traditional shared savings [ Medicaid ]*
>
> *Or Payment Model Selection = Utilization-based shared savings [ Commercial ]*
>
> *Or Payment Model Selection = Utilization-based shared savings [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Utilization-based shared savings [ Medicaid ]*
>
> *Or Payment Model Selection = Fee-for-service-based shared risk [ Commercial ]*
>
> *Or Payment Model Selection = Fee-for-service-based shared risk [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Fee-for-service-based shared risk [ Medicaid ]*
>
> *Or Payment Model Selection = Procedure-based bundled/episode payments [ Commercial ]*
>
> *Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicaid ]*
>
> *Or Payment Model Selection = Population-based payments that are NOT condition-specific [ Commercial ]*
>
> *Or Payment Model Selection = Population-based payments that are NOT condition-specific [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Population-based payments that are NOT condition-specific [ Medicaid ]*
>
> *Or Payment Model Selection = Condition-specific, population-based payments [ Commercial ]*
>
> *Or Payment Model Selection = Condition-specific, population-based payments [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Condition-specific, population-based payments [ Medicaid ]*
>
> *Or Payment Model Selection = Condition-specific bundled/episode payments [ Commercial ]*
>
> *Or Payment Model Selection = Condition-specific bundled/episode payments [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Condition-specific bundled/episode payments [ Medicaid ]*
>
> *Or Payment Model Selection = Full or percent of premium population-based payments [ Commercial ]*
>
> *Or Payment Model Selection = Full or percent of premium population-based payments [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Full or percent of premium population-based payments [ Medicaid ]*
>
> *Or Payment Model Selection = Integrated finance and delivery programs [ Commercial ]*
>
> *Or Payment Model Selection = Integrated finance and delivery programs [ Medicare Advantage ]*
>
> *Or Payment Model Selection = Integrated finance and delivery programs [ Medicaid ]*

Q18 Please select which set of accountable care APM questions your organization will report on below. *In some situations, health plans/states may attribute members to both a PCP/PCG and a non-PCP (i.e., specialist). In these instances, please attribute members to either the PCP/PCG or the non-PCP focused accountable care APM questions but not both.*

○ Primary care physician (PCP) and primary care group (PCG) focused accountable care questions  (1)

○ Non-primary care physician focused accountable care questions  (2)

**End of Block: Accountable Care APM Selection**

**Start of Block: Primary Care Physician and Primary Care Group Focused Accountable Care Metric**

*Display This Question:*

*If LOB selection = Commercial*

*And Please select which set of accountable care APM questions your organization will report on below.... = Primary care physician (PCP) and primary care group (PCG) focused accountable care questions*

*And Please select which set of accountable care APM questions your organization will report on below.... != Non-primary care physician focused accountable care questions*

**Q19 Commercial Line of Business Primary Care Physician and Primary Care Group Focused Accountable Care Metric**

Please list the total number of Commercial health plan members by Category who are attributed/aligned/assigned/empaneled to PCP or PCG participating in a TCOC **Category 3A, Category 3B, or Category 4** accountable care APM of six months or longer in CY 2022 or most recent 12 months.

*Display This Answer:*

    *If Payment Model Selection = Traditional shared savings [ Commercial ]*

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

*Display This Answer:*

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

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

*Display This Answer:*

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

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

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

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

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

| | | |
|---|---|---|
| *Display This Answer:* | *Display This Answer:* | *Display This Answer:* |
| *If Payment Model Selection = Traditional shared savings [ Commercial ]* | *If Payment Model Selection = Fee-for-service-based shared risk [ Commercial ]* | *If Payment Model Selection = Population-based payments that are NOT condition-specific [ Commercial ]* |
| *Or Payment Model Selection = Utilization-based shared savings [ Commercial ]* | *Or Payment Model Selection = Procedure-based bundled/episode payments [ Commercial ]* | *Or Payment Model Selection = Condition-specific, population-based payments [ Commercial ]* |
| Category 3A - shared savings (1) | Category 3B - shared risk (2) | *Or Payment Model Selection = Condition-specific bundled/episode payments [ Commercial* |

| | | | |
|---|---|---|---|
| | | | *]*<br>*Or Payment Model Selection = Full or percent of premium population-based payments [ Commercial ]*<br>*Or Payment Model Selection = Integrated finance and delivery programs [ Commercial ]*<br>All of Category 4 (4A, 4B, 4C combined) (3) |
| Commercial (1) | | | |

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**Q20 <u>Medicare Advantage Line of Business Primary Care Physician and Primary Care Group Focused Accountable Care Metric</u>**

Please list the total number of Medicare Advantage health plan members by Category who are attributed/aligned/assigned/empaneled to PCP or PCG participating in a TCOC **<u>Category 3A, Category 3B, or Category 4</u>** accountable care APM of six months or longer in CY 2022 or most recent 12 months.

*Display This Answer:*

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

> *Or Payment Model Selection = Utilization-based shared savings [ Medicare Advantage ]*

*Display This Answer:*

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

> *Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicare Advantage ]*

*Display This Answer:*

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

> *Or Payment Model Selection = Condition-specific, population-based payments [ Medicare Advantage ]*

> *Or Payment Model Selection = Condition-specific bundled/episode payments [ Medicare Advantage ]*

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

> *Or Payment Model Selection = Integrated finance and delivery programs [ Medicare Advantage ]*

| | | |
|---|---|---|
| *Display This Answer:*<br><br>*If Payment Model Selection = Traditional shared savings [ Medicare Advantage ]*<br><br>*Or Payment Model Selection = Utilization-based shared savings [ Medicare Advantage ]*<br><br>Category 3A - shared savings (1) | *Display This Answer:*<br><br>*If Payment Model Selection = Fee-for-service-based shared risk [ Medicare Advantage ]*<br><br>*Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicare Advantage ]*<br><br>Category 3B - shared risk (2) | *Display This Answer:*<br><br>*If Payment Model Selection = Population-based payments that are NOT condition-specific [ Medicare Advantage ]*<br><br>*Or Payment Model Selection = Condition-specific, population-based payments [ Medicare Advantage ]*<br><br>*Or Payment Model Selection = Condition-specific* |

| | | | |
|---|---|---|---|
| | | | *bundled/episode payments [ Medicare Advantage ]* |
| | | | *Or Payment Model Selection = Full or percent of premium population-based payments [ Medicare Advantage ]* |
| | | | *Or Payment Model Selection = Integrated finance and delivery programs [ Medicare Advantage ]* |
| | | | All of Category 4 (4A, 4B, 4C combined) (3) |
| Medicare Advantage (2) | | | |

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Q21 **Medicaid Line of Business Primary Care Physician and Primary Care Group Focused Accountable Care Metric**

Please list the total number of Medicaid health plan members by Category who are attributed/aligned/assigned/empaneled to PCP or PCG participating in a TCOC **Category 3A, Category 3B, or Category 4** accountable care APM of six months or longer in CY 2022 or most recent 12 months.

> *Display This Answer:*
>
> > *If Payment Model Selection = Traditional shared savings [ Medicaid ]*
> >
> > *Or Payment Model Selection = Utilization-based shared savings [ Medicaid ]*
>
> *Display This Answer:*
>
> > *If Payment Model Selection = Fee-for-service-based shared risk [ Medicaid ]*
> >
> > *Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicaid ]*
>
> *Display This Answer:*
>
> > *If Payment Model Selection = Population-based payments that are NOT condition-specific [ Medicaid ]*
> >
> > *Or Payment Model Selection = Condition-specific, population-based payments [ Medicaid ]*
> >
> > *Or Payment Model Selection = Condition-specific bundled/episode payments [ Medicaid ]*
> >
> > *Or Payment Model Selection = Full or percent of premium population-based payments [ Medicaid ]*
> >
> > *Or Payment Model Selection = Integrated finance and delivery programs [ Medicaid ]*

| | | |
|---|---|---|
| *Display This Answer:* <br><br> *If Payment Model Selection = Traditional shared savings [ Medicaid ]* <br><br> *Or Payment Model Selection = Utilization-based shared savings [ Medicaid ]* <br><br> Category 3A - shared savings (1) | *Display This Answer:* <br><br> *If Payment Model Selection = Fee-for-service-based shared risk [ Medicaid ]* <br><br> *Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicaid ]* <br><br> Category 3B - shared risk (2) | *Display This Answer:* <br><br> *If Payment Model Selection = Population-based payments that are NOT condition-specific [ Medicaid ]* <br><br> *Or Payment Model Selection = Condition-specific, population-based payments [ Medicaid ]* <br><br> *Or Payment Model Selection = Condition-specific bundled/episode payments [ Medicaid ]* <br><br> *Or Payment Model* |

| | | | |
|---|---|---|---|
| | | | *Selection = Full or percent of premium population-based payments [ Medicaid ]*<br><br>*Or Payment Model Selection = Integrated finance and delivery programs [ Medicaid ]*<br><br>All of Category 4 (4A, 4B, 4C combined) (3) |
| Medicaid (3) | | | |

*Display This Question:*

*If Please select which set of accountable care APM questions your organization will report on below.... = Non-primary care physician focused accountable care questions*

*And Please select which set of accountable care APM questions your organization will report on below.... != Primary care physician (PCP) and primary care group (PCG) focused accountable care questions*

*And LOB selection = Commercial*

**Q22 <u>Commercial Line of Business Non-Primary Care Physician (i.e., specialist) Focused Accountable Care Metric</u>**

Please list the total number of Commercial health plan members by Category who are attributed/aligned/assigned/empaneled  to non-PCPs (i.e., specialists) participating in a TCOC **<u>Category 3 or Category 4</u>** accountable care APM of six months or longer in CY 2022 or most recent 12 months.

*Display This Answer:*

> *If Payment Model Selection = Traditional shared savings [ Commercial  ]*
>
> *Or Payment Model Selection = Utilization-based shared savings [ Commercial  ]*
>
> *Or Payment Model Selection = Fee-for-service-based shared risk [ Commercial  ]*
>
> *Or Payment Model Selection = Procedure-based bundled/episode payments [ Commercial  ]*

*Display This Answer:*

> *If Payment Model Selection = Population-based payments that are NOT condition-specific [ Commercial  ]*
>
> *Or Payment Model Selection = Condition-specific, population-based payments [ Commercial  ]*
>
> *Or Payment Model Selection = Condition-specific bundled/episode payments [ Commercial  ]*
>
> *Or Payment Model Selection = Full or percent of premium population-based payments [ Commercial ]*
>
> *Or Payment Model Selection = Integrated finance and delivery programs [ Commercial  ]*

| | | |
|---|---|---|
| | *Display This Answer:*<br><br>*If Payment Model Selection = Traditional shared savings [ Commercial  ]*<br><br>*Or Payment Model Selection = Utilization-based shared savings [ Commercial  ]*<br><br>*Or Payment Model Selection = Fee-for-service-based shared risk [ Commercial  ]*<br><br>*Or Payment Model Selection = Procedure-based bundled/episode payments [ Commercial  ]*<br><br>All of Category 3 (3A and 3B combined) (1) | *Display This Answer:*<br><br>*If Payment Model Selection = Population-based payments that are NOT condition-specific [ Commercial  ]*<br><br>*Or Payment Model Selection = Condition-specific, population-based payments [ Commercial  ]*<br><br>*Or Payment Model Selection = Condition-specific bundled/episode payments [ Commercial  ]*<br><br>*Or Payment Model Selection = Full or percent of premium population-based payments [ Commercial  ]*<br><br>*Or Payment Model Selection* |

|  |  | = *Integrated finance and delivery programs [ Commercial ]* |
|  |  | All of Category 4 (4A, 4B, 4C combined) (2) |
| Commercial (1) |  |  |

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Page Break ———————————————————————

**Q23 <u>Medicare Advantage Line of Business Non-Primary Care Physician (i.e., specialist) Focused Accountable Care Metric</u>**

Please list the total number of Medicare Advantage health plan members by Category who are attributed/aligned/assigned/empaneled to non-PCPs (i.e., specialists) participating in a TCOC **<u>Category 3 or Category 4</u>** accountable care APM of six months or longer in CY 2022 or most recent 12 months.

*Display This Answer:*

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

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

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

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

*Display This Answer:*

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

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

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

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

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

| *Display This Answer:* | *Display This Answer:* |
|---|---|
| *If Payment Model Selection = Traditional shared savings [ Medicare Advantage ]* | *If Payment Model Selection = Population-based payments that are NOT condition-specific [ Commercial  ]* |
| *Or Payment Model Selection = Utilization-based shared savings [ Medicare Advantage ]* | *Or Payment Model Selection = Condition-specific, population-based payments [ Commercial  ]* |
| *Or Payment Model Selection = Fee-for-service-based shared risk [ Medicare Advantage ]* | *Or Payment Model Selection = Condition-specific bundled/episode payments [ Commercial  ]* |
| *Or Payment Model Selection = Procedure-based bundled/episode payments [ Commercial  ]* | *Or Payment Model Selection = Full or percent of premium population-based payments [ Medicare Advantage ]* |
| All of Category 3 (3A and 3B combined) (1) | *Or Payment Model Selection* |

|  |  | = *Integrated finance and delivery programs [ Medicare Advantage ]* |
|  |  | All of Category 4 (4A, 4B, 4C combined) (2) |
| Medicare Advantage (2) |  |  |

Page Break

Q24 **Medicaid Line of Business Non-Primary Care Physician (i.e., specialist) Focused Accountable Care Metric**

Please list the total number of Medicaid health plan members by Category who are attributed/aligned/assigned/empaneled to non-PCPs (i.e., specialists) participating in a TCOC **Category 3 or Category 4** accountable care APM of six months or longer in CY 2022 or most recent 12 months.

*Display This Answer:*

    *If Payment Model Selection = Traditional shared savings [ Medicaid ]*

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

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

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

*Display This Answer:*

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

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

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

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

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

| | *Display This Answer:* | *Display This Answer:* |
|---|---|---|
| | *If Payment Model Selection = Traditional shared savings [ Medicaid ]* | *If Payment Model Selection = Population-based payments that are NOT condition-specific [ Medicaid ]* |
| | *Or Payment Model Selection = Utilization-based shared savings [ Medicaid ]* | *Or Payment Model Selection = Condition-specific, population-based payments [ Medicaid ]* |
| | *Or Payment Model Selection = Fee-for-service-based shared risk [ Medicaid ]* | *Or Payment Model Selection = Condition-specific bundled/episode payments [ Medicaid ]* |
| | *Or Payment Model Selection = Procedure-based bundled/episode payments [ Medicaid ]* | *Or Payment Model Selection = Full or percent of premium population-based payments [ Medicaid ]* |
| | | *Or Payment Model Selection = Integrated finance and delivery programs [ Medicaid ]* |
| | All of Category 3 (3A and 3B combined) (1) | All of Category 4 (4A, 4B, 4C |

| | | combined) (2) |
|---|---|---|
| Medicaid (4) | | |

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).

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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)

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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)

-------------------------------------------------------------------------------------------------

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)

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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)

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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)

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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)

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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.

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✳

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  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)

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.