

ROADMAP

for Driving High Performance
in Alternative Payment Models

Methodology Report



Introduction	3
Part I: Overview.....	5
High-Level Description of Information Inputs and Methodology.....	5
LAN Guiding Committee	5
<i>Roadmap</i> Work Group	5
<i>Roadmap</i> Implementation Group.....	6
Key Processes.....	6
Part II: Approach to Identifying Successful APMs.....	7
Introduction and Methodology	7
Inclusion Criteria	7
Domains of Success.....	8
Using Domains of Success to Identify Successful APMs	8
Success Criteria	9
Operationalizing Success Criteria.....	10
Where:	11
Where:	11
Information Collection and Interpretation	12
Limitations	16
Lessons Learned	17
Part III: Approach to Identifying Promising Practices and Challenges for Successful APM Implementation	17
Challenges for Successful APM Implementation	17
Introduction and Methodological Overview.....	17
Background Research.....	17
Scope of Challenges and Promising Practices for APM Implementation	18
Identifying Payers and Providers to Interview.....	18
Interview Process.....	19
Limitations	20
Lessons Learned	20
Appendix A: Work Group Members and Affiliations	21
Appendix B: Data Collection Tool and Specifications	22
<i>Roadmap</i> Data Collection Template Specifications	22

Overview	22
Specialty APMs.....	25
Appendix C: Pre-interview Questionnaire for Providers	29
Pre-interview Questionnaire for Providers.....	29
Provider Success Factors.....	29
Provider Organizational Characteristics.....	30
Patient Population Characteristics.....	31
APM Experience.....	31
Information Technology.....	33
Appendix D: Interview Question Bank.....	33
Question Bank for Best Practice Interviews.....	33
Possible Questions for Payers.....	33
Possible Questions for Providers	43

Introduction

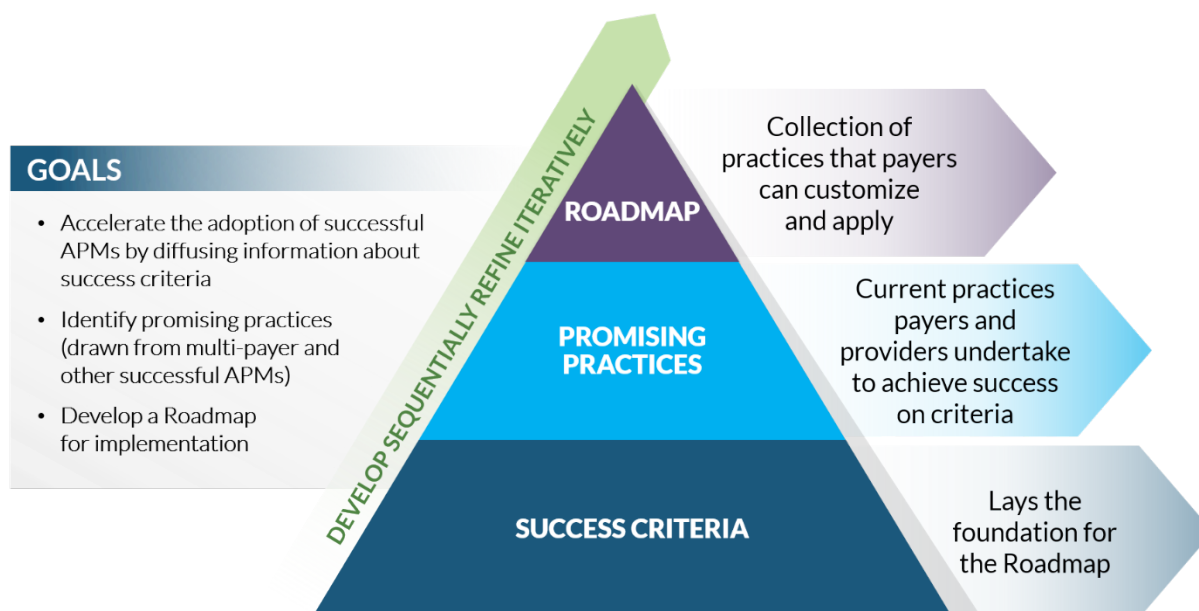
This methodological report supplements the *Roadmap for Driving High Performance in Alternative Payment Models (APMs)* initiative (i.e., “*Roadmap*”) by providing additional details about the methods used to identify and describe promising practices covered in the *Roadmap* and by discussing some of the lessons learned over the course of conducting the work.

On January 29, 2018, the Health Care Payment Learning and Action Network (HCP-LAN) Guiding Committee met to prioritize initiatives for the HCP-LAN. The Guiding Committee considered several options and analyzed them based on their potential impact to more rapidly advance payment reform. The clear consensus was to pursue work on a “*Roadmap*” for implementing successful alternative payment models (APMs) that drive high performance.

The *Roadmap* starts from the premise that simply increasing APM adoption is a necessary but insufficient goal for payment reform. Rather, the goal should be to increase the adoption of APMs that contribute directly to lowering health care costs and improving the quality of care, while also improving patient and provider experience. The *Roadmap* therefore aims to facilitate the adoption of successful payment models by diffusing information on key characteristics and promising practices drawn from regional experiences and other innovators in the field.

The *Roadmap* focuses on promising practices for APM design and implementation for both payers and providers, which improve patient care, and particularly the collaboration between payers and providers. An APM is defined as a specialty or population-based payment model administered by public and/or private payers, and successful APMs demonstrate high aggregate performance across provider participants within the model. Similarly, successful provider participants effectively manage the health of their patient populations within the payment environment of the APM, delivering efficient, high-quality care and a positive patient experience. Although many of the promising practices that drive successful APMs are generally understood at a high level, tactical details about successful APM implementation are not widely available. Therefore, the *Roadmap* aspires to accelerate the learning curve for implementing successful APMs, by diffusing tactical information about the promising practices that payers and providers use to meet stakeholder expectations and the ways that providers and payers can effectively collaborate with each other and other stakeholders to improve patient care.

Figure 1: Overview of the Roadmap Initiative



As illustrated in Figure 1, the *Roadmap* was conceptualized in three levels that build upon each other and culminate in an implementation guide consisting of promising practices from payers and providers. Success criteria used to identify high-performing APMs provide the foundation of the work by helping determine where to look for promising practices for high performance. Promising practices then emerged from interviews with payers who implemented successful APMs and their provider participants. Finally, this collection of promising practices fed into the *Roadmap* implementation guide for how to adopt promising practices and how to overcome common challenges.

Given the magnitude of the task and the complexity of the subject matter, the *Roadmap* represents a pilot study and will require additional investigation to fully validate its findings. As discussed in more detail below, constraints imposed by a pilot study carry limitations on the conclusions that can be drawn from the work. Nevertheless, this phase of the *Roadmap* offers an approach (and an associated set of tools used during the data collection and interview process) that can be used subsequently to scale the *Roadmap* effort, and it offers a rich set of findings that will be valuable for advancing the goals of payment reform.

This document explains the methodology used to reach key decisions and ultimately obtain information about promising practices for successful APMs. It also summarizes the decisions about how to characterize successful APMs and how to identify the promising practices of successful APMs and provider participants.

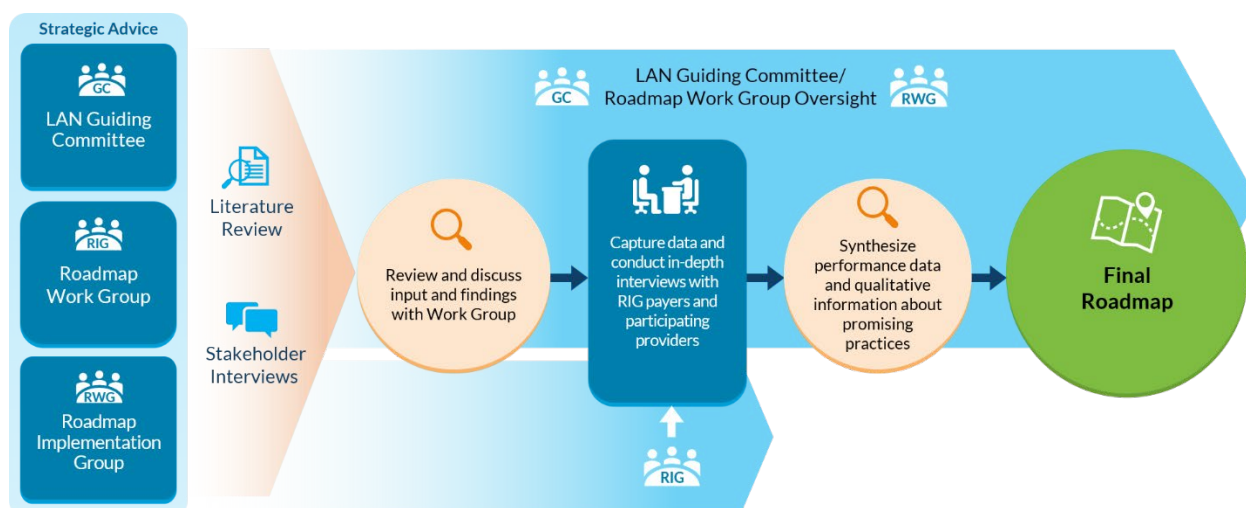
Part I: Overview

High-Level Description of Information Inputs and Methodology

The HCP-LAN collected a wide variety of information from a diverse set of inputs on promising practices of successful APMs and provider participants. These information sources, and ways in which the information was used, are illustrated in Figure 2 and summarized below.

Prior to assessing APM performance data and conducting in-depth interviews on promising practices, the HCP-LAN conducted background research (i.e., Literature Review and Stakeholder Interviews) with the help of three strategic advisory groups: the LAN Guiding Committee, the *Roadmap* Work Group, and the *Roadmap* Implementation Group. The primary role of the *Roadmap* Implementation Group centered on the collection of promising practices through performance data and in-depth interviews, whereas the LAN Guiding Committee and *Roadmap* Work Group helped synthesize information and served to oversee the development of the final *Roadmap*.

Figure 2: Methodological Approach to the Roadmap Initiative



LAN Guiding Committee

The LAN Guiding Committee is the primary leadership body of the LAN and collaborates with the CMS Alliance to Modernize Healthcare (CAMH) on strategy, establishment and oversight of work groups, and dissemination of results, among other things.

Roadmap Work Group

In response to the charge from the Guiding Committee, HCP-LAN convened a multistakeholder *Roadmap* Work Group (i.e., the “Work Group”) to oversee the *Roadmap* and to provide strategic and tactical guidance. Work Group members represented payers, providers, purchasers,

patients/consumers, and regional health care collaboratives. Work Group members and their stakeholder affiliations can be found in [Appendix A](#).

The role of the Work Group was to reach consensus on the scope of the work and to make key decisions about the conclusions reached in the *Roadmap*. As discussed in more detail below, the Work Group focused on two areas: (1) defining what constitutes a successful APM (see [Part II](#)) and (2) identifying the range of promising practices to collect and the process for collecting them.

Roadmap Implementation Group

The HCP-LAN convened the *Roadmap* Implementation Group (i.e., the “RIG”), composed of nine national and regional payers, including CMS, in order to operationalize success criteria the Work Group specified (see [Operationalizing Success Criteria](#)) and provide detailed performance and descriptive information about high-performing APMs (see [Information Collection and Interpretation](#) and [Interview Process](#)). The RIG nominated APMs they considered to be high-performing according to specified criteria. Performance and descriptive information helped better explain outcomes achieved by high-performing APMs and included criteria that payers used to evaluate their own success, ranges of risk sharing with providers, and APM design components. This information was used to gain a better understanding of the range of APMs that are currently in operation. Additionally, the RIG connected the HCP-LAN with providers in their high-performing APMs, which gave critical insight to the provider perspective in the *Roadmap*.

Key Processes

A. Literature review and stakeholder interviews

In addition to their work on identifying success criteria (see [Part II](#)), the Guiding Committee and Work Group both shaped and provided constant feedback on the [literature review](#) and participated in stakeholder interviews. Both the literature review and stakeholder interviews (see [Background Research](#)) were used to develop an [interview guide](#) for payers and providers, particularly focusing on tactical details about how to implement promising practices that address common challenges. RIG members also participated in initial stakeholder interviews.

B. Interviews with RIG Members and their participating providers

RIG members and providers participating in their high-performing APMs were interviewed to identify promising practices and challenges for APM implementation on both sides of the payer/provider relationship (see [Interview Process](#)). These interviews were used to collect tactical information about how to implement promising practices, how to overcome common barriers to implementation, and how to collaborate more effectively with other stakeholders. This tactical information formed the basis for the implementation guide.

Part II: Approach to Identifying Successful APMs

Introduction and Methodology

The Work Group was asked to reach consensus on the criteria that should be used to identify successful APMs. By forming a diverse multistakeholder Work Group, the HCP-LAN ensured that these success criteria reflected various perspectives. This was seen as important, given the multistakeholder composition of the HCP-LAN and the importance of implementing APMs that meet the needs of many different stakeholders.

A four-step process was adopted to establish criteria that could be used to identify successful APMs:

1. Identify inclusion criteria for APMs that could potentially be considered high performing to narrow the *Roadmap*'s focus to particular types of APMs.
2. Define the domains that would be used to assess APMs.
3. Develop a high-level process for using the domains to identify a subset of successful APMs.
4. Further specify success criteria for two of the domains that played crucial roles in the APM selection process, drawing on expertise from the *Roadmap* Implementation Group (RIG), as described below.

The following section discusses details associated with each step in the process. It also describes the data that were received from members of the RIG and how the Work Group interpreted that data.

Inclusion Criteria

The *Roadmap* is intended to be broadly applicable and reflect different types of APMs (specialty and population based), across all lines of business, different regions of the country, and diverse types of provider organizations (e.g., size and type of provider organizations). Nevertheless, it was important to establish inclusion criteria to enhance the impact and validity of its findings:

1. **APMs in Categories 3 and 4 of the HCP-LAN APM Framework:**
The *Roadmap* focuses on Category 3 and 4 APMs (i.e., upside/downside risk and population-based payments) because payers and providers face the greatest challenges implementing these APMs and because of the critical importance of helping providers move into risk-bearing arrangements.
2. **Minimum of three years in operation:**
Payers are constantly innovating APMs, and new APMs may substantially improve the quality and effectiveness of care delivery. Nevertheless, novel APMs that lack a proven track record of success may not be the best source for promising practices that are sustainable over the long term. Therefore, the *Roadmap* focuses on APMs that have been operational for at least three years.

Domains of Success

To determine the expectations that different stakeholders had of APMs, the HCP-LAN conducted preliminary research by interviewing representative stakeholders, Guiding Committee members, and other experts about the types of benefits that APMs should bring to the health care system, how they would define a successful APM, and how they would determine whether an APM met their definition of success. **Out of this research, five potential domains emerged:**

1. **Cost:** APMs should reduce cost of care for payers, the cost of insurance coverage for purchasers, and out-of-pocket costs for patients.
2. **Quality:** APMs should improve the quality of care for patients, preferably determined by high scores on outcome measures that are meaningful to patients and consumers.
3. **Patient experience:** APMs should improve patients' experience of care, particularly with respect to the ease of accessing care that is covered by insurance plans.
4. **Provider experience:** APMs should reduce administrative burden for providers and preserve clinical autonomy.
5. **Health Equity:** APMs should improve health equity by reducing health disparities where they exist.

APMs examined in the *Roadmap* would ideally demonstrate success in all of the five domains.¹

Using Domains of Success to Identify Successful APMs

Having established domains of success within which APMs must demonstrate positive outcomes, it was important to consider how the domains would be used to identify successful APMs. The identification of successful APMs entails a retrospective analysis of performance, which would ideally be based upon comparable performance data. Therefore, it was not realistic to assess APMs on domains of success that they were not intended to impact. For example, early APM implementation may have solely focused on containing costs and improving quality, rather than explicitly focusing on health equity.

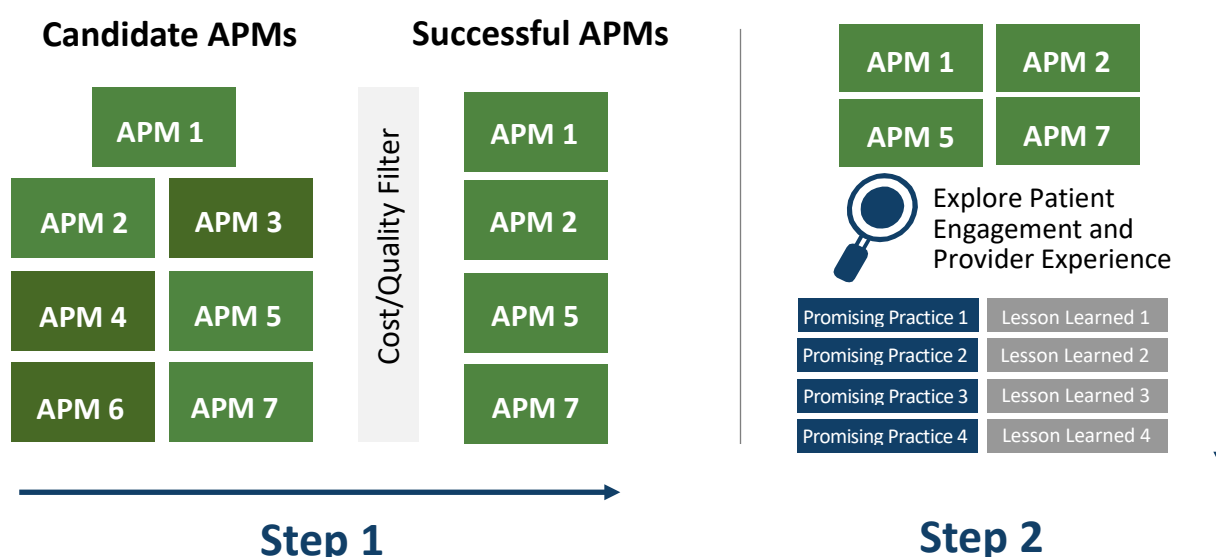
Taking these considerations into account, performance in the cost and quality domains represented the primary “filtering” criteria for identifying successful APMs. That is, APMs investigated for promising practices needed to reduce costs as well as improve quality.

The other three domains were not used as filtering criteria. Despite the critical importance of improving patient experience and care accessibility, the Work Group was concerned about the availability and comparability of patient experience performance information as well as how well assessments of care

¹ One additional domain that was considered but not included was care delivery transformation. Recognizing that delivery system transformation is the fundamental objective of payment reform, success domains in the Roadmap focus on outcomes (e.g., cost or quality outcomes), as opposed to processes that were presumed to bring about positive outcomes. This is because including nonoutcomes-based success criteria (e.g., structural and procedural characteristics of APMs) may introduce a methodological circularity: i.e., the Roadmap would use promising practices to identify exemplary APMs, rather than using positive outcomes to identify APMs that exemplify promising practices. Care delivery transformation was therefore not included as a success domain because it was a process, as opposed to an outcome. Nevertheless, promising practices associated with effective practice transformation are critically important, and these practices are highlighted in the Roadmap.

experience actually measured patient experience. Many successful APMs are not designed to address health equity, so it was difficult to collect meaningful performance information on disparity reductions. And, plans do not consistently track provider experience and would have a difficult time demonstrating success in this domain. Given these challenges, using these three domains as filtering criteria for successful APMs would overly restrict the number of successful APMs that could be investigated for promising practices, which would limit the utility of the implementation guide. Therefore, the HCP-LAN investigated promising practices and positive outcomes associated with success in the domains of patient experience, provider experience, and health equity among APMs that demonstrated high performance on cost and quality. This process for using domains to identify successful APMs is illustrated in Figure 3 below.

Figure 3: Using Domains to Identify Successful APMs



Success Criteria

Having established a process for identifying successful APMs, the Work Group further considered how to measure successful outcomes in the cost and quality domains and what levels of achievement successful APMs should ideally demonstrate within these domains.

With respect to the cost domain, the Work Group decided that successful outcomes for population-based APMs should be measured in terms of total cost of care (TCOC). Similarly, the Work Group decided that successful outcomes for specialty models should be measured in terms of cost per episode.

With respect to the quality domain, it would not be possible to collect performance information on quality measures that were not currently collected or calculated in the APMs. It was also unreasonable to expect APMs to demonstrate high performance on quality measures that were not included in payment models. Therefore, the Work Group decided that successful APMs should demonstrate high performance on each APM's own measure set.

Beyond metrics, the Work Group also deliberated on levels of cost and quality performance that would be considered. The Work Group decided that successful APMs should ideally fall into the bottom quartile on cost performance and the top quartile on quality performance among all APMs in operation.

Taken together, the success criteria for cost and quality are illustrated in Figure 4.

Figure 4: Success Criteria for Cost and Quality²

Cost	Quality
Population-Based Models <ul style="list-style-type: none"> Performance Metric: Total Cost of Care Performance Range: Bottom quartile of cost performance Specialty Models <ul style="list-style-type: none"> Performance Metric: Cost per episode times volume of episodes Performance Range: Bottom quartile of cost performance 	Population-Based Models <ul style="list-style-type: none"> Performance Metric: Aggregate performance of APM on common set of reported measures Performance Range: Top quartile of quality performance Specialty Models <ul style="list-style-type: none"> Performance Metric: Aggregate performance on measures used in the APM Performance Range: Top quartile of quality performance

Operationalizing Success Criteria

Although the Work Group possesses considerable expertise and experience with APM implementation, it was less equipped to address the technical challenges associated with collecting data from payers that accurately reflect APM performance on the cost and quality criteria that the Work Group specified. Therefore, the *Roadmap* convened a separate group of payer representatives with deep expertise in APM implementation and evaluation. This *Roadmap* Implementation Group (RIG) consisted of individuals from eight commercial plans as well as CMS. These members were selected because, collectively, they represented more than half of the covered lives in the country and because they had considerable experience innovating and implementing APMs. Given the time frame for capturing the promising practices of successful APMs for an implementation guide, the Work Group decided to limit the scope of the *Roadmap* to APMs that RIG payers implemented, which also met the inclusion criteria described above.

Once convened, the RIG focused on which types of data would truly reflect APM performance on the Work Group's success criteria for cost and quality. RIG discussions revolved around the specification of a data collection tool that RIG members could use to report information to the *Roadmap* initiative (see [Appendix B](#) for a copy of the data collection tool and specifications for the tool).

² As discussed in the next section, it was not possible to fully operationalize the Work Group's success criteria.

Ultimately, the RIG recommended reporting performance information in terms of “market-normalized” ratios, which reflect an APM’s aggregate cost and quality performance relative to the performance of peer providers in the same market that did not participate in the APM. The RIG recommended this approach because it normalizes market-based cost and quality variation, which can be considerable in different parts of the country. The RIG also recommended market-normalized cost and quality ratios to reduce variation in the methods payers used to calculate TCOC, medical loss ratios (where used as an alternative to TCOC), cost per episode, and quality measure scores. These ratios would therefore improve the comparability of performance data across APMs. Following the RIG’s guidance, these market-normalized cost and quality ratios were constructed as follows:

$$\text{Market-Normalized Costs} = \frac{\text{Actual Costs}}{\text{Cost Benchmarks}}$$

Where:

- Actual costs = Aggregated costs (as payers currently calculate it) of all participating providers within the APM; and
- Cost benchmark = Aggregated costs (using the same calculations) for peer providers in the same market who are not participating in the APM

$$\text{Market-Normalized Quality} = \frac{\text{Actual Quality}}{\text{Quality Benchmarks}}$$

Where:

- Actual quality = Aggregated performance on a quality measure (as payers currently calculate it) of all participating providers within the APM; and
- Quality benchmark = Aggregated performance on the same quality measure (using the same calculations) for peer providers in the same market who are not participating in the APM

In further considering how to report performance data that would address the Work Group’s success criteria for cost and quality, the RIG noted limitations associated with reporting market-normalized ratios that aggregated data across all providers that participated in an APM for different lengths of time. In particular, providers participating in an APM in a given year reflect a wide range of experience with population health management, and the performance of inexperienced providers (who join the APM in years two or three of APM implementation) could “dilute” the significant achievements of more experienced providers. This could result in underestimating the true performance of the APM. Therefore, the RIG recommended collecting market-normalized ratios associated with specific provider cohorts in order to better track improvements among consistent sets of providers as they gain experience participating in an APM.

Although the RIG agreed that cohort-specific, market-normalized cost and quality ratios provide the best available method for reporting performance data that meaningfully addressed the Work Group’s success criteria, questions remained about the feasibility of reporting this data in the time frame needed

to develop the *Roadmap*. Therefore, in an effort to reduce the burden of reporting on RIG members, the data collection tool was specified to accept three types of market-normalized ratios:

- **Provider Cohort-Specific:** Market-normalized ratios based on cohorts of providers that entered the APM in the same year, such that cost and quality ratios are reported according to each provider cohort.
- **All Provider Cohorts:** Market-normalized ratios based on all providers that ever participated in the APM, such that cost and quality ratios are aggregated across all providers in a given year (regardless of the year providers entered the APM).
- **Initial Provider Cohort:** Market-normalized ratios based on all providers that entered into the APM during the first year, such that cost and quality ratios are only reported for this initial provider cohort.

RIG members were also given the option of reporting APM performance data in the manner in which it was currently captured in order to improve the overall response rate. The Work Group recognized that this approach to data collection would result in less comparable data, but Work Group members considered incomparable data preferable to not collecting any data and limiting the scope of APMs examined for the *Roadmap*.

Information Collection and Interpretation

Table 1: APM Data Submitted

Model Type	Number of Models Submitted	LAN Categories Represented	Line(s) of Business
Accountable Care Organizations (ACO)	3*	3A**	Commercial, Medicaid
Patient-centered Medical Homes (PCMH)	2	3A, 4A	Commercial, Medicaid, MA
Clinical Episode	3*	3A, 3B, 4A	Commercial, Medicare FFS, MA

*Payers additionally nominated 1 ACO and 1 clinical episode model for which performance data were not submitted. These two models are excluded from the count of APMs for which data were submitted.

**ACOs submitted largely fell under the 3A category (shared savings only) though payers noted there was limited participation in 3B arrangements (shared risk).

Table 2: Episode Types Submitted

Episode(s)	Episode Type
Total Knee/Hip Replacement (x3)	Procedure
Perinatal (x2)	Condition
Cholecystectomy	Procedure
Tonsil/Adenoidectomy	Procedure
Percutaneous Coronary Intervention (x2)	Procedure

Approved for Public Release; Distribution Unlimited. Public Release Case Number 19-0826.

©2019 The MITRE Corporation. ALL RIGHTS RESERVED

Coronary Artery Bypass Graft	Procedure
Acute Exacerbations of Asthma	Procedure
Acute Exacerbations of COPD	Procedure
Bariatric Surgery	Procedure
Renal Failure	Procedure

RIG members submitted data for five population-based models and three types of episode-based models that covered 10 distinct conditions and procedures (outlined in Table 2 above).

RIG members submitted data in various formats, including the “provider cohort-specific” and “all provider cohort” options described above. Additionally, RIG members submitted data in other formats not specified above. Although some RIG members used market-normalized ratios, others submitted different cost and quality performance units (see Table 3). Due to the varying submission methods and units submitted, it proved infeasible to meaningfully aggregate data across population-based or episode-based models.

Table 3: Types of Data Submitted

Data Type	Number of Payers
Annual, provider cohort-specific, market-normalized cost and quality data	1
Annual market-normalized cost and quality data, aggregated across providers	4
Other	5

Generally, however, it is reasonable to conclude that APMs nominated by the RIG have demonstrated meaningful cost and quality performance improvements relative to market. RIG data also provided insights into the current state of quality measure alignment in population-based APMs.

Cost performance data indicated that population-based APMs generally outperform the market on cost with about 5-10 percent lower market-normalized costs. Generally, APM quality performance was also better relative to market, with a range of about 10-20 percent higher scores on certain quality measures, and in some cases, up to 25 percent better.

Quality measure sets submitted in population-based APMs largely included Healthcare Effectiveness Data and Information Set (HEDIS, <https://www.ncqa.org/hedis/>) measures though there was a significant lack of alignment across the measures used (see Table 4).

It was difficult to draw general conclusions on cost or quality performance in episode-based models, given the smaller number of models submitted, variability in episodes submitted, and lack of comparability in measure sets for the same episode (see Table 5 for examples of measures used in clinical episode models across payers).

Table 4: Measures Used in Population-Based Payment Models

Measure	Specs	# of Plans Using Measure in APM
Breast Cancer Screening	HEDIS	4
Diabetes: HbA1c Testing	HEDIS	4
Cervical Cancer Screening	HEDIS	3
Diabetes: Nephropathy	HEDIS	3
Colorectal Cancer Screening	HEDIS	2
Appropriate Treatment for Children with Upper Respiratory Infection	HEDIS	2
Annual Monitoring for Patients on Persistent Medications	HEDIS	2
Well-Child Visits Ages 3-6 Years Old	HEDIS	2
Diabetes: Eye	HEDIS	2
Use of Imaging Studies for Low Back Pain	HEDIS	2
Immunizations for Adolescents	HEDIS	2
ER Visits / 1,000	Other	2
Childhood Immunization Status	HEDIS	1
Appropriate Testing for Children with Pharyngitis	HEDIS	1
Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults	HEDIS	1
Diabetes: HbA1c <8%	HEDIS	1
Adult BMI Assessment	HEDIS	1
Persistence of Beta-Blocker Treatment After a Heart Attack	HEDIS	1
Well-Child Visits in the First 15 Months of Life	HEDIS	1
Adolescent Well-Care Visits	HEDIS	1
Postpartum Care	HEDIS	1
Children's Access to Care	HEDIS	1
Antibiotic Stewardship Summary	HEDIS	1
Antidepressant Medication Management	HEDIS	1
Chlamydia Screening in Women	HEDIS	1
Follow-Up Care for Children Prescribed ADHD Medication	HEDIS	1
Medication Management for People With Asthma	HEDIS	1
Antirheumatic Drug Therapy for Rheumatoid Arthritis	HEDIS	1
Osteoporosis Management in Women Who Had a Fracture	HEDIS	1
Pharmacotherapy Management of COPD Exacerbation	HEDIS	1
Potentially Preventable Admissions Rate (PPA)	Other	1
Potentially Preventable Readmission Rate (PPR)	Other	1
Potentially Preventable ER Visits (PPV)	Other	1
Admit Rate per 1,000 per month	Other	1

Readmission Rate	Other	1
Generic Rx Rate	Other	1
Rx per Enrollee per Month	Other	1
Imaging Rate per 1,000 per Month	Other	1
Screening for Tobacco Use	NQF	1
Screening for Clinical Depression Using a Standardized Tool	NQF	1

Table 5: Measures Used in Clinical Episode Models

Quality Measures used by Episode
Cholecystectomy Quality Measures
Percent of episodes with CT scan prior to cholecystectomy
Rate of major complications that occur in common bile duct injury
Rate of major complications that occur in episode bowel perforation or injury
Rate of major complications that occur in episode abdominal blood vessel injury
Bariatric Surgery Quality Measures
Readmissions
ER visits
Perinatal Quality Measures
Readmissions
ER visits
HIV screening
Group B streptococcus screening (GBS)
Chlamydia screening
Screening for gestational diabetes
Screening for UTI asymptomatic bacteriuria
Hepatitis B (Hep B)–specific antigen screening
Total Knee/Hip Replacement Quality Measures
30-day, all-cause readmission rate
Percent of use of prophylaxis against postop deep venous thrombosis (DVT)/pulmonary embolism (PE) (pharmacologic or mechanical compression)
Percent of postop DVT/PE
30-day wound infection rate
Postop complication rate
Percutaneous Coronary Intervention Quality Measures
Readmissions
ER visits
Percent of PAPs with ≥95% of episodes not flagged for adverse outcomes
Percent of patients with any adverse outcomes
Percent of patients with myocardial infarction
Percent of patients with stroke
Percent of patients with stent thrombosis
Percent of patients with postop hemorrhage
Percent of patients with AV fistula

Percent of patients with pulmonary embolism
Percent of patients with wound infection
Coronary Artery Bypass Graft Quality Measures
Average length of preprocedure inpatient stay
Percentage of patients admitted on day of procedure
Percentage of patients for which an internal mammary artery is used

Limitations

There were several limitations in examining APM performance data. First, the scope of the *Roadmap* was limited to APMs nominated by payers on the RIG, and performance data were not submitted for all APMs, effectively limiting the representativeness of the data and the APMs investigated in the *Roadmap*. Second, APMs nominated were required to have been implemented for a minimum of three years to demonstrate sustainability of performance results, which may have also limited payers from nominating a wider range of newer APMs. In particular, this likely limited the number of downside-risk APMs that the RIG nominated because those APMs tended to be more recent than upside-only APMs. Third, owing to RIG membership, some lines of business were better represented than others (commercial and Medicare Advantage were more represented than Medicare FFS and Medicaid APMs), which made it difficult to draw conclusions about promising practices that are specific to a particular line of business. Finally, performance data were self-reported, and market-normalized ratios were calculated by payers; the data were not audited, and the *Roadmap* did not examine claims. It was therefore not feasible to verify the accuracy of data submitted.

As previously mentioned, variation in data submitted also limited the extent to which performance data could be aggregated to draw further conclusions about cost and quality performance. Despite general agreement that provider cohort-specific market-normalized ratios may best evaluate APM performance, the limited time frame hampered RIG members' ability to prepare the data accordingly. In addition to different data formats and units of comparison, payers use different quality measure sets across APMs, further limiting comparability.

Lessons Learned

Payers assess APM cost and quality performance in various ways, which makes it challenging to evaluate performance compared to their peers. The RIG determined that provider cohort-specific market-normalized ratios best evaluate APM cost and quality performance since they assess cost and quality impact in a given market for a given cohort of providers. Regardless, most payers were unable to calculate these ratios in the given time frame. The lack of a standardized system for evaluating performance may be an important gap for future consideration. Closing this gap would better allow payers to compare their APM's performance to other APMs in their line of business, and purchasers could leverage this information to make informed decisions when contracting with payers. Further, a standardized system of evaluating APM performance in a uniform way across payers, markets, and populations would facilitate comparisons of performance across APMs and would complement the HCP-LAN's efforts to standardize the measurement of APM adoption.

Part III: Approach to Identifying Promising Practices and Challenges for Successful APM Implementation

Introduction and Methodological Overview

In addition to establishing success criteria to identify successful APMs and collecting data on APM characteristics and performance, the HCP-LAN also conducted interviews with payers and providers to investigate promising practices and common challenges associated with implementing successful APMs. This section describes the background research that supported approaches to collecting this information, and it explains the scope of challenges and promising practices to include in the *Roadmap*. It also describes the process that was used to identify interview subjects and conduct interviews that were capable of capturing actionable information about APM implementation.

Background Research

The HCP-LAN conducted a targeted literature review about what was already known about successful APM implementation for two reasons. First, gaining a deeper understanding of the complexities of the subject matter—which touches on federal and state regulations, clinical standards, organizational processes, data analyses, contractual negotiations, and clinical and financial risk assessment—was important for understanding the issues that payers and providers face and asking relevant and targeted questions about particular approaches. Second, it was important to confirm through research that the state of knowledge about promising practices for APM implementation—particularly payer promising practices—is still in the early stages of development to ensure there was a need in the field for this type of information. Findings from this research are available in a report entitled *Exploring APM Success Factors: Insights from a Focused Review*, which can be found on the *Roadmap* [website](#).

Scope of Challenges and Promising Practices for APM Implementation

From the outset, there was a strong consensus among Work Group and Guiding Committee members that it would be critical to collect promising practices from both payers and providers. This is because both stakeholders undertake distinct yet interconnected activities to implement successful APMs and because an APM's success can be contingent on effective collaboration between payers and providers. Accordingly, interviews were structured to elicit details about the division of responsibilities between payers and providers at different stages in the implementation process as well as areas of significant interaction in order to identify opportunities for payers and providers to better collaborate with each other and other stakeholders. Following guidance from the Guiding Committee and Work Group, patient and consumer representative interviews about best practices for APM implementation were also conducted, and this information was taken into account when describing best practices in the *Roadmap*.

Identifying Payers and Providers to Interview

As discussed previously, the scope of the *Roadmap* was limited to APMs implemented by payers on the RIG due to the pilot nature of the initiative. Altogether, the HCP-LAN conducted interviews with representatives from eight payer organizations in the public and private sectors.

In order to understand the perspective of providers participating in the APMs under consideration, the *Roadmap* was limited to providers participating in APMs nominated by RIG members. Therefore, an element was included within the data collection tool for RIG members to identify provider points of contact for interviews about promising practices and challenges. In order to collect promising practices and challenges that were broadly applicable for a wide range of providers that participate in APMs, it would be ideal to interview providers along a spectrum of success. For example, promising practices used by the highest-performing provider organizations are undoubtedly valuable for other providers that are able to emulate them. Perspectives about challenges for APM implementation from providers who had yet to achieve high performance could also offer valuable lessons about the way payers design and operate APMs. And, perspectives about promising practices from providers who demonstrate rapid improvement could offer insights into how to prioritize the implementation of promising practices. In the course of discussions with RIG members, however, it became evident that information about where a particular provider fell within the spectrum of success would be difficult to obtain due to the sensitivity of providers on the lower end of the spectrum. Ultimately, RIG members were asked to identify providers with different ranges of experience (1 year, 2 years, and 3+ years of participation). However, very few of the providers identified had 0-1 year of experience. Altogether, RIG members identified 20 providers, of which the *Roadmap* conducted interviews with representatives from nine small practices and four integrated delivery systems participating in population-based and clinical-episode models.

Interview Process

The following process was used to collect challenges and promising practices from payers and providers:

1. **Collect background information about APM and provider characteristics and the practices they attribute to their success:** To understand the context in which payers and providers operate, and to focus interviews on challenges and promising practices for APM implementation, the HCP-LAN collected background information from payers and providers ahead of the scheduled interviews. Specifically, information about APM characteristics (e.g., categories in the HCP-LAN APM framework and payment mechanisms employed) was requested through the [data collection tool](#), and information about provider organization characteristics (e.g., size of organization and patient demographics) was collected through a preinterview questionnaire (see [Appendix C](#)). To elicit the most specific and tactical descriptions of promising practices, the HCP-LAN also asked payers and providers to identify the top contributors to their success before they participated in interviews. Information about payer and provider characteristics and their promising practices was used to structure individualized interview scripts, as discussed below.
2. **Interview structure:** As mentioned previously, both the literature review and the external stakeholder interviews captured perspectives and findings about the challenges and practices associated with successful APM implementation. These findings served as the basis for a question bank (see [Appendix D](#)), which included detailed questions about common promising practices and challenges uncovered in the background research (e.g., financial benchmarking strategies in the case of payers and care coordination strategies in the case of providers). The HCP-LAN considered background information about payer and provider characteristics and promising practices and selected questions from the question bank that were most directly relevant to construct individualized interview scripts for each interview conducted. High-level questions were sent ahead of time to allow interview subjects to gather internal information and include individuals who possessed relevant knowledge in the interviews. Overall, interview scripts for each organization shared many commonalities. For example, all payers were asked about their efforts to support providers with data sharing and data analytics as well as their approaches to APM design (e.g., financial benchmarking and quality measurement); all providers were similarly asked about their approach to care coordination, data analytics, and patient engagement. This tailored, semiuniform approach to interview scripting provided consistency in the information obtained, while capturing key nuances and contextual factors that impacted promising practices and challenges for specific payers and providers. Payer and provider interviews typically lasted 90 minutes. Interviews were typically recorded and transcribed to facilitate analysis and synthesis.
3. **Analysis and presentation of interview data:** The HCP-LAN used NVivo—qualitative research software—to analyze interview transcripts and coded similar information together for the purpose of reconstructing practices and challenges that were highlighted by multiple interview subjects. Information about practices and challenges was described in the *Roadmap* even if it came from a single source, but certain details were occasionally excluded to preserve anonymity.

Limitations

There were several limitations associated with the approach used to gather promising practices and challenges from payer and provider interviews. First, given time and resource constraints, it was not possible to identify and interview patients who received care through APMs that were included in the *Roadmap*. It therefore was not possible to include patient perspectives on the care they received and assess the extent to which they believed the APM was successful in achieving outcomes that mattered to them. Second, providers interviewed in the *Roadmap* were limited to a small number of small practices and an even smaller number of larger integrated delivery systems. It is therefore possible that the promising practices they used are not generalizable to practices in similar situations, that their perspectives are not fully representative of the experience of all providers, and that the practices they identified do not include practices that other providers employ to succeed in APMs. Third, most of the providers interviewed for the *Roadmap* considered themselves successful and achieved positive cost and quality outcomes. It was therefore not possible to validate that the promising practices described in the *Roadmap* are unique to successful providers and not shared by providers who struggle to succeed in APMs. Finally, promising practices described in the *Roadmap* are limited to the details that payers and providers were willing to share and might not include tactical advice that interview subjects consider proprietary or competitive. It is therefore possible that descriptions of promising practices in the *Roadmap* are missing key details that are important for successfully implementing APMs.

Lessons Learned

Overall, the interview approach used to identify and detail promising practices was very successful for capturing tactical information about approaches to APM implementation from payers and providers who participated in interviews. Payers and providers were typically receptive to providing information ahead of the interviews, and the questions posed during the interviews usually elicited extensive, detailed responses (though in some cases, responses were limited to protect sensitive information).

Nevertheless, it was very time consuming and resource intensive to schedule interviews with payers and providers, and there was a low overall response rate from providers identified by payers (i.e., 65 percent). This was likely attributable to the time commitment associated with participating in interviews and the lack of a direct, concrete benefit for doing so. Additionally, as discussed above, it proved impossible to identify and interview providers across the spectrum of success due to sensitivities of payers and perceived sensitivities of providers. Although it is possible to use publically available data to identify providers across the spectrum of success in Medicare APMs, additional approaches will need to be developed to identify and interview a similar range of providers in APMs used by private payers.

Part IV: Appendices

Appendix A: Work Group Members and Affiliations

Thomas Buckingham (Chair)*

Executive Vice President
Select Medical

Craig Brammer

Chief Executive Officer
The Health Collaborative

Steve Farmer, MD

Senior Advisor and Medical Officer
CMMI

JD Fischer

Senior Health Policy Analyst
Washington State Health Care Authority

Susan Frampton, PhD

President
Planetree International

Andrea Gelzer, MD

Senior Vice President & Corporate Chief Medical Officer
AmeriHealth Caritas

Steve Hussey

Senior Vice President, Compensation & Benefits
Western & Southern Financial Group

David Kendrick, MD

Chief Executive Officer
MyHealth Access Network

Renee McLaughlin, MD FACS

National Medical Director, Value-Based Relationships
Cigna

Angelo Sinopoli, MD

Vice President, Clinical Integration and Chief Medical Officer
Greenville Health System

***Craig Samitt, MD**

(originally chaired the Work Group though transitioned off due to external circumstances)
President and CEO
Blue Cross and Blue Shield of Minnesota

Appendix B: Data Collection Tool and Specifications

The data collection tool can be accessed online at <http://hcp-lan.org/workproducts/%20data-collection.pdf>

Roadmap Data Collection Template Specifications

Overview

The Data Collection tool is designed to collect a variety of performance and descriptive information from plans about their APMs. Separate tabs are available to report information about population-based and specialty APMs. If plans submit information on more than one of either type of APM, they can copy the appropriate tab and create a new label (e.g., “PBP APM 2” or “Specialty APM 3”).

Population-Based Payment APMs

I. Contact Information

- a. Contact information for plan POC: provide the name, title, email, and phone number for the individual whom the *Roadmap* team can contact with questions and to schedule interviews about best practices.
- b. Contact information for provider POC: provide the name, organization, title, email, and phone number for the individual whom the *Roadmap* team can contact to schedule interviews about best practices. If possible, the *Roadmap* team requests at least one contact for each of the following types of providers:
 - i. 1 year participating in the APM: provider organizations that have been participating in the APM for about a year or less.
 - ii. 2 years participating in the APM: provider organizations that have been participating in the APM for about two years.
 - iii. 3+ years participating in the APM: provider organizations that have been participating in the APM for three or more years.

If possible, it would be ideal to connect with a variety of providers, e.g., providers who live in different parts of the country, providers in physician groups as well as hospitals/health systems, and providers in small and large practices.

II. Performance Information

- a. **Overview:** In the interest of reducing the burden of reporting performance information, there are three options for reporting:
 - Provider Cohort-Specific: Pull data according to cohorts of providers that entered the APM in the same year and report cost and quality ratios according to each provider cohort.
 - All Provider Cohorts: Pull data for all providers that ever participated in the APM and report aggregated cost and quality ratios for all providers.
 - Initial Provider Cohort: Pull data for all providers that entered into the APM during the first years and report cost and quality ratios for this initial provider cohort.

It is only necessary to report according to one of these three options. The preferred approach is to report according to provider cohorts, and the least-favored approach is to report according to initial provider cohort.

b. Cost

- i. Market-Normalized Cost Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
 1. Numerator (“Actual TCOC”): Aggregated total cost of care, as you are currently calculating it, of all participating providers within the APM.
 2. Denominator (“TCOC Benchmark”): Applying the same calculations used in the numerator, aggregated total cost of care for peer providers in the same market who are not participating in the APM.

$$\text{Market – Normalized Total Cost} = \frac{\text{Actual Total Cost}}{\text{Total Cost Benchmark}}$$

- ii. Cost Units: Indicate whether you assess cost performance of the model in terms of total cost of care (TCOC) or medical loss ratio (MLR).

c. Quality

- i. Measure: List the name of the measure that was used to assess quality performance in the APM.
- ii. Market-Normalized Quality Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
 1. Numerator (“Actual TCOC”): Aggregated quality-of-care performance of all participating providers within the APM.
 2. Denominator (“TCOC Benchmark”): Aggregated quality-of-care performance for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized Quality} = \frac{\text{Actual Quality}}{\text{Quality Benchmarks}}$$

- iii. Specification: In the “specification” field, report which measure specifications were used (e.g., NQF, HEDIS, CMS, other in-house specification).

d. Method for establishing peer group for cost and quality ratios:

- Describe the method used to assign providers that did not participate in the APM to the denominator of the cost and quality ratios.

III. Descriptive Information:

a. APM Attributes

- i. Market: Report the census region of the market(s) the APM is operating in.

- ii. Line of business: Report line of business (e.g., MA, Medicaid, commercial, or Medicare FFS).
- iii. Product line: Report product line (e.g., HMP, PPO, or POS).
- iv. Percent of network participating in APM: Report the percent of your provider network in the line of business that is participating in the APM.
- v. Provider composition: Indicate types of providers participating in the APM (e.g., primary care, hospital, specialty, post-acute care) by checking boxes to the left of provider types that participate.
- vi. Percent of attributed members/beneficiaries: Report the percent of members or beneficiaries within the line of business who are attributed to the APM.
- vii. Years in operation: Report the number of years the APM has been in operation
- viii. Average duration of provider contracts: Report roughly how many years an APM contract with a provider organization lasts, on average.
- ix. Multipayer model: Indicate whether the APM is multipayer.
- x. LAN APM category: Specify which category and subcategory in the LAN APM framework that this APM falls into.
- xi. Type and level of risk: Estimate the range (as percentages) of shared savings and shared risk that participating providers take on, as applicable.
- xii. Payment mechanism: Report types of payments included in the APM, such as upfront or per-member-per-month (PMPM) payments to support infrastructure development, bonus payments for cost or quality performance, shared savings with upside or downside risk, and prospective, population-based payments.
- xiii. Provider selection criteria: Report the high-level criteria you look for when entering into a contract with a provider organization.
- xiv. APM criteria for success: Describe the approach you use to determine if an APM is successful.

- IV. Total Cost of Care or Medical Loss Ratio Calculations:** This section provides additional information on total cost of care or medical loss ratio calculations:
- a. Behavioral Health Carve-In: Indicate “yes” if behavioral health costs are carved into total cost of care calculations and “no” if they are not. Additional information (e.g., services covered and proportion of TCOC) can be added to the “Please Explain” field.
 - b. Pharmacy Spend Carve-In: Indicate “yes” if pharmacy costs are carved into total cost of care calculations and “no” if they are not. Additional information (e.g., services covered and proportion of TCOC) can be added to the “Please Explain” field.
 - c. Incentive Payments: Indicate “yes” if performance incentive payments are included in total cost of care calculations and “no” if they are not. Additional information (e.g., services covered and proportion of TCOC) can be added to the “Please Explain” field.
 - d. Other Carve-Ins Included: Indicate “yes” if other nontraditional health care costs (e.g., spending on transportation, housing, and other social support services) are included in total cost of care calculations and “no” if they are not. Additional information about the types of costs that are carved in can be added to the “Please Explain” field.
 - e. Risk-Adjustment Methodology: Provide information on the risk-adjustment methodology used in calculating total cost of care (e.g., general methodology, variables accounted for).

- f. Method for Addressing Outlier Payments: Provide information on the methodology used to address outlier payments (e.g., general methodology, variables accounted for).
- V. **Best Practices**
- The primary objective of the *Roadmap* is to develop an implementation guide that payers can use to collaborate with other stakeholders to implement successful APMs, i.e., APMs that demonstrate high performance on cost and quality across all participating providers. We are interviewing plans to identify the best practices they used to implement successful APMs, and the implementation guide will be heavily based on the best practices identified in the course of the interviews. These practices may pertain to the way the APM was designed at the outset, or they may have to do with the activities the plan used to help support providers as the APM was implemented. Based on your experience, can you explain at a high level (i.e., 1-2 sentences each) the top contributors to your success? Possible examples of best practices may include analytic support for providers or using regional cost trends to set financial benchmarks.
- VI. **Supplemental Information**
- Provide additional information not captured elsewhere in the data collection tool that the *Roadmap* should take into account when considering the success of the APM.
- VII. **Additional Questions**
- a. Patient Experience: Check the box to report that the APM assesses patient experience and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., shared decision-making, active patient engagement, positive experience of care, whether patient experience assessment is tied to payments) can be reported in the “Please Explain” field.
 - b. Provider Experience: Check the box to report that the APM assesses provider experience and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., timely data exchange, low administrative burden, proactive technical assistance, financial support) can be reported in the “Please Explain” field.
 - c. Health Equity: Check the box to report that the APM assesses health equity and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., lowering disparities in access and health outcomes, and cultural competence) can be reported in the “Please Explain” field.

Specialty APMs

- VIII. **Contact Information**
- a. Contact information for plan POC: provide the name, title, email, and phone for the individual whom the *Roadmap* team can contact with questions and to schedule interviews about best practices.
 - b. Contact information for provider POC: provide the name, organization, title, email, and phone for the individual whom the *Roadmap* team can contact to schedule interviews about best practices. The *Roadmap* team requests at least one contact for each of the following types of providers:

- i. 1 year participating in the APM: provider organizations that have been participating in the APM for about a year or less.
- ii. 2 years participating in the APM: provider organizations that have been participating in the APM for about two years.
- iii. 3+ years participating in the APM: provider organizations that have been participating in the APM for three or more years.

If possible, it would be ideal to connect with a variety of providers, e.g., providers who live in different parts of the country, providers in physician groups as well as hospitals/health systems, and providers in small and large practices.

IX. Performance Information

a. **Overview:** In the interest of reducing the burden of reporting performance information, there are three options for reporting:

- Provider Cohort-Specific: Pull data according to provider cohorts that entered the APM in the same year and report cost and quality ratios according to each provider cohort.
- All Provider Cohorts: Pull data for all providers that ever participated in the APM and report cost and quality ratios according to each provider cohort.
- Initial Provider Cohort: Pull data for all providers that entered into the APM during the first years and report cost and quality ratios for this initial provider cohort.

It is only necessary to report according to one of these three options. The preferred approach is to report according to provider cohorts, and the least-favored approach is to report according to initial provider cohort.

b. Cost

- i. Market-Normalized Cost Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
 1. Numerator (“Actual TCOC”): Aggregated cost per episode, as you are currently calculating it, of all participating providers within the APM.
 2. Denominator (“TCOC Benchmark”): Applying the same calculations used in the numerator, aggregated cost per episode for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized Cost per Episode} = \frac{\text{Actual Cost per Episode}}{\text{Cost per Episode Benchmark}}$$

- ii. Volume of Episodes: Report the number of episodes performed by providers in the APM during the past four years of operation.

c. Quality

- i. Measure: List the name of the measure that was used to assess quality performance in the APM.
- ii. Market-Normalized Quality Ratios: Calculate, but do not report, the following numerators and denominators for the past four years of operation. For each year, report the results of the ratio based on the following calculations for numerators and denominators:
 1. Numerator (“Actual TCOC”): Aggregated quality-of-care performance of all participating providers within the APM.
 2. Denominator (“TCOC Benchmark”): Aggregated quality-of-care performance for peer providers in the same market who are not participating in the APM.

$$\text{Market-Normalized} = \frac{\text{Actual Quality}}{\text{Quality Benchmarks}}$$

- iii. Specification: In the “specification” field, report which measure specifications were used (e.g., NQF, HEDIS, CMS, other in-house specification).

d. Method for establishing peer group for cost and quality ratios:

- Describe the method used to assign providers that did not participate in the APM to the denominator in the cost and quality ratios.

I. Descriptive Information:

a. APM Attributes

- i. Market: Report the census region of the market(s) the APM is operating in.
- ii. Line of business: Report line of business (e.g., MA, Medicaid, commercial, or Medicare FFS).
- iii. Product line: Report product line (e.g., HMP, PPO, or POS).
- iv. Percent of network participating in APM: Report the percent of your provider network in the line of business that is participating in the APM.
- v. Provider composition: Indicate types of providers participating in the APM (e.g., primary care, hospital, specialty, post-acute care) by checking boxes to the left of provider types that participate.
- vi. Percent of attributed members/beneficiaries: Report the percent of members or beneficiaries within the line of business who are attributed to the APM.
- vii. Years in operation: Report the number of years the APM has been in operation.
- viii. Average duration of provider contracts: Report roughly how many years an APM contract with a provider organization lasts, on average.
- ix. Multipayer model: Indicate whether the APM is multipayer.
- x. LAN APM category: Specify which category and subcategory in the LAN APM framework that this APM falls into.
- xi. Type and level of risk: Estimate the range (as percentages) of shared savings and shared risk that participating providers take on, as applicable.

- xii. Payment mechanism: Report types of payments included in the APM, such as upfront or PMPM payments to support infrastructure development, bonus payments for cost or quality performance, shared savings with upside or downside risk, and prospective, population-based payments.
- xiii. Provider selection criteria: Report the high-level criteria you look for when entering into a contract with a provider organization.
- xiv. APM criteria for success: Describe the approach you use to determine if an APM is successful.

b. Episode Parameters

- i. Episode Type: Report episode type (e.g., cardiac, hip and knee, or oncology).
- ii. Episode Duration: Report duration of episode (e.g., 30, 60, or 90 days for hip and knee bundles, or from cancer diagnosis through termination of treatment for oncology bundles).
- iii. Risk Adjustment: Provide information on the risk-adjustment methodology used in calculating cost per episode.
- iv. Patient Population: Report patient population.
- v. Services/Costs Included: Report the services and costs included in the APM (e.g., acute, postacute, drugs).

II. Best Practices

- The primary objective of the *Roadmap* is to develop an implementation guide that payers can use to collaborate with other stakeholders to implement successful APMs, i.e., APMs that demonstrate high performance on cost and quality across all participating providers. We are interviewing plans to identify the best practices they used to implement successful APMs, and the implementation guide will be heavily based on the best practices identified in the course of the interviews. These practices may pertain to the way the APM was designed at the outset, or they may have to do with the activities the plan used to help support providers as the APM was implemented. Based on your experience, can you explain at a high level (i.e., 1-2 sentences each) the top contributors to your success? Possible examples of best practices may include analytic support for providers or using regional cost trends to set financial benchmarks.

III. Supplemental Information

- Provide additional information not captured elsewhere in the data collection tool that the *Roadmap* should take into account when considering the success of the APM.

IV. Additional Questions

- a. Patient Experience: Check the box to report that the APM assesses patient experience and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., shared decision-making, active patient engagement, positive experience of care, whether patient experience assessment is tied to payments) can be reported in the “Please Explain” field.
- b. Provider Experience: Check the box to report that the APM assesses provider experience and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., timely data exchange, low administrative

burden, proactive technical assistance, financial support) can be reported in the “Please Explain” field.

- c. Health Equity: Check the box to report that the APM assesses health equity and demonstrates high levels of achievement in this domain. Additional information about assessments and accomplishments (e.g., lowering disparities in access and health outcomes, and cultural competence) can be reported in the “Please Explain” field.

Appendix C: Pre-interview Questionnaire for Providers

Pre-interview Questionnaire for Providers

The Pre-interview Questionnaire will be used to obtain information about characteristics of the provider organization outside of the interview itself. The Questionnaire also asks providers to identify (in a sentence or two) the best practices they plan to highlight during the interview. Providers will need to identify best practices ahead of the interview, but they can send information about provider characteristics separately.

Name of Payer and APM:

Name of Organization:

Provider Success Factors

The primary objective of the *Roadmap* is to develop an implementation guide that payers can use to collaborate with other stakeholders to implement successful APMs, i.e., APMs that demonstrate high performance on cost and quality across all participating providers. We are interviewing providers to identify the best practices they use to achieve success within APMs, and the implementation guide will be heavily based on the best practices identified in the course of these interviews. These practices may pertain to care delivery redesign to better support population health management and associated approaches to quality improvement, cost controls, or patient, or they may have to do with the activities the plan used to help support providers as the APM was implemented. **Based on your experience, can you explain at a high level (i.e., 1-2 sentences each) the top contributors to your success?** Possible examples may include a team-based approach to population health management or robust patient engagement programs.

Response:

Provider Organizational Characteristics

Organizational Characteristics. Please describe the characteristics of your organization:

☐ Size: _____

- Health Systems

- Number of organizations within your health system participating in the APM:
 - Hospitals: _____
 - Long-Term Care Hospitals: _____
 - Skilled Nursing Facilities: _____
 - Psychiatric Hospitals: _____
 - Primary Care Practices: _____
 - Single Specialty Practices: _____
 - Multispecialty Practices: _____
 - Home Health Organizations: _____
 - Hospice Organizations: _____
 - Other: _____

Individual Hospital

- Number of beds: _____
- Number of employed physicians: _____

Physician Practices

- For primary care practices, # employed clinicians³: _____
- For primary care practices, # patients/visits annually: ____/____
- For single specialty practices, # employed clinicians: _____
- For single specialty practices, # patients/visits annually: ____/____
- For multispecialty practices, # employed clinicians: _____
- For multispecialty practices, # patients/visits annually: ____/____
- Number of locations: _____
- Number of locations participating in the APM: _____

What type and how many postacute organizations do you work with to implement the APM, and to what degree are their incentives (financial or otherwise) aligned with your incentives in the APM?

What type and how many specialists do you work with to implement the APM, and to what degree are their incentives (financial or otherwise) aligned with your incentives in the APM?

³ Clinician includes physicians, nurse practitioners, physician assistants, or others with a medical or nursing degree who treat patients.

Is your organization accredited?

- ☐ Yes. What type of accreditation (ACO, hospital, PCMH, etc.)? _____
 - Accreditation Organization(s): _____
- ☐ No

Are you affiliated with a larger health system or academic medical center?

- ☐ Yes
- ☐ No

Roughly what percent of your revenue comes from value-based contracts with upside or upside and downside risk?

Patient Population Characteristics.

Does your patient population include many patients who are economically disadvantaged?

- ☐ Yes
- ☐ No

Does your patient population include many patients with complex, chronic conditions?

- ☐ Yes
- ☐ No

APM Experience.

How long have you been contracted under this particular APM?

- ☐ One year or less
- ☐ Two to three years
- ☐ Three to five years
- ☐ More than five years

Generally speaking, how long have you been engaged in any alternative payment model efforts that have shared savings or downside risk?

- ☐ One year or less
- ☐ Two to three years
- ☐ Three to five years
- ☐ More than five years

How many separate contracts do you have for alternative payment models that include shared savings (upside risk only)?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 5-10
- ☐ More than 10

With how many payers? _____

How many separate contracts do you have for alternative payment models that include downside risk?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 5-10
- ☐ More than 10

With how many payers? _____

Please list the other APMs in which your organization participates (both commercial and public payers, such as Anthem's Enhanced Personal Care model or Medicare's Comprehensive Primary Care Plus model):

Information Technology.

Describe your information technology infrastructure:

EHR system(s):

Is the system certified EHR technology?

- ☐ Yes
☐ No

Level of interoperability within the organization:

Level of interoperability outside of the organization:

Level of decision support built into EHR:

Please describe your internal data analytics capabilities:

Appendix D: Interview Question Bank

Question Bank for Best Practice Interviews

Possible Questions for Payers

Background

- Can you give us a high-level overview of your APM?
- Can you describe your APM's approach to quality measurement? How did you select quality measures, and how do you tie quality to payment?
- Can you describe your APM's approach to financial benchmarking?
- Can you describe your APM's approach to patient attribution?
- Who was involved in the design of your APM?
 - (If episode-based payment model: How do you work with providers to define clinical episodes for bundles?)
- Are there other aspects of your APM's design that are worth discussing further?

APM Design: Patient attribution

- Can you explain your approach/methodology for patient attribution and why it is responsible for improving cost and quality?
 - (Potentially – can you explain your patient attribution algorithm?)
- Does your approach to attribution vary from provider to provider?

- (Potentially – if so, how?)
- At what stage in the implementation process did you tackle attribution, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to attribution evolved over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to patient attribution?
- How did you address issues associated with patient churn and leakage?
- Was your approach to attribution aligned with patient incentives in benefit design (e.g., copays, deductibles)?
- Why do you think that your patient attribution methodology was substantially responsible for the APM's success?

APM Design: Benefit design

- Can you explain your approach to benefit design and why it is responsible for improving cost and quality?
- How and to what extent do patient incentives align with incentives for providers in the APM?
- Does your approach to attribution vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you tackle benefit design, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to benefit design evolved over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to benefit design?
- Was your approach to attribution aligned with patient incentives in benefit design (e.g., copays, deductibles)?
- Why do you think that your patient attribution methodology was substantially responsible for the APM's success?

APM Design: Benchmarking

- Can you explain your financial benchmarking methodology and why it is responsible for improving cost and quality?
- Do you use organization-specific (i.e., historical) or regional benchmarks—or some combination?
 - (Potentially - how quickly do financial benchmarks converge on regional cost trends?)
- Does your approach to benchmarking vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you tackle benchmarking, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to benchmarking evolved over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to financial benchmarking?

- Do your benchmarks incentivize the participation of lower-performing providers?
 - (Potentially – if so, how?)
- Do your benchmarks incentivize the participation of higher-performing providers?
 - (Potentially – if so, how?)
- How do you incorporate improvement and achievement in the model?
- Can you discuss any issues you've faced with risk adjustment and the ways you resolved them?
- Can you discuss any issues you've faced with outlier costs (particularly with respect to expenditures on novel drug therapies) and the ways you resolved them?
- Why do you think the benchmarking methodology was substantially responsible for the APM's success?

APM Design: Use of meaningful measures

- Can you explain your approach to quality measurement, including the testing and implementation of quality measures and why it is responsible for improving cost and quality?
- Does your approach to quality measurement vary from provider to provider? Do the measures you use vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you tackle quality measurement, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to quality measurement evolved over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to quality measurement?
- How did you select the measures used in the APM? Do you include clinical and patient-reported outcome measures?
- To what extent are your measures aligned with measures used in comparable APMs offered by other payers in the market?
- Do you perceive important gaps in available measures?
 - (Potentially – if so, what are they?)
- Can you discuss any issues you've faced with the quality-reporting infrastructure and the ways you resolved them?
- How and how regularly do you share performance data with your providers?
- How does performance on quality measures impact payment?
- What types of clinical and administrative data do providers need to report, outside of claims?
- Why do you think this approach to performance measurement was substantially responsible for the APM's success?

APM Design: Gradual increase of levels of risk sharing

- Can you describe how and how quickly does providers' financial risk change as they gain experience in the APM and why it is responsible for improving cost and quality?
- Does your approach to provider risk vary from provider to provider?
 - (Potentially – if so, how?)
- What is your approach for moving providers into downside risk arrangements?

- What types of considerations do you take into account when making decisions about how much financial risk a provider is able to take, and which provider characteristics are most important?
- At what stage in the implementation process did you establish your approach to risk sharing, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to provider risk evolved over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to providers' financial risk?
- To what extent are providers able to anticipate changes in financial risk, such as changes to risk corridors or minimum loss rates?
- Why do you think this approach to risk sharing was substantially responsible for the APM's success?

APM Design: Payment structure

- Can you describe your approach to structuring payments within the APM and why you believe this approach was responsible for improvements in cost and quality?
- Do payment structures in the APM vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you design your approach to payment structures, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to payment structures evolved over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to payment structures?
- Why do you think this approach to selecting providers was substantially responsible for the APM's success?

APM Design: Provider selection

- What types of considerations do you take into account when making decisions about whether to move a provider into an APM, and why is it responsible for improving cost and quality?
- At what stage in the implementation process did you establish provider selection criteria, what steps did you take, and to what extent were providers involved in key decisions?
- Have your standards for participation changed as the APM has matured?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to provider selection?
- Why do you think this approach to selecting providers was substantially responsible for the APM's success?

APM Design: Medical management of providers

- What steps do you take to manage the way that providers design and operate their care delivery systems, and what types of requirements do you use? Why were these policies responsible for improvements in cost and quality?
- (If episode-based payment model: Can you describe your approach to standardizing clinical practices in the episodes? How do you deal with appropriateness, both in terms of patients who qualify for the episode and for the episode itself? How did your approach to clinical standardization improve cost and quality among participating providers?)
- At what stage in the implementation process did you establish medical management policies, what steps did you take, and to what extent were providers involved in key decisions?
- Have your medical management policies changed as the APM has matured?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your medical management policies?
- Does your APM loosen prior authorization requirements as providers take on additional financial risk?
- Why do you think this approach to selecting providers was substantially responsible for the APM's success?

Provider Supports: Timely data sharing

- Can you explain your overarching approach to data sharing with providers, the data architecture that you use, and why it is responsible for improving cost and quality?
- What types of data do you share with providers; how frequently is it shared?
- Does your approach to data sharing vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you tackle data sharing, what steps did you take, and to what extent were providers involved in key decisions?
- Has your approach to data sharing changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to data sharing?
- Do you support data sharing between providers?
 - (Potentially – if so, how?)
- Can you describe the analytic reports that you share with providers (e.g., benchmarking reports)?
- Do you collaborate with other payers to give providers standardized reports?
- Can you describe your efforts to streamline the data you share with providers and make it more actionable?
- Do you have a sense of whether providers use the data and reports that you generate?
- Do you share data that are granular enough for providers to perform their own analytics and independently assess their performance in the APM?
- Do you support data sharing with patients?

- (Potentially – if so, what types of platforms do you use, and what types of personal health information can they access?)
- (Potentially – if so, do you share providers’ cost and quality performance data with patients?)
- Why do you think this approach to data sharing was substantially responsible for the APM’s success?

Provider Supports: Technical assistance with data analytics

- Can you explain the types of data analytic support and data reports you offer providers and why it is responsible for improving cost and quality?
- Does your approach to data analytic support vary from provider to provider? Does your approach to technical assistance differ in one-sided versus two-sided risk arrangements?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you establish data analytic support programs, what steps did you take, and to what extent were providers involved in key decisions about how they should operate?
- Has your approach to data analytic support changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to data analytic support?
- Do you use administrative data to identify care gaps and share this information with providers?
- Do you help providers identify high-risk patients or manage patients with similar care needs?
- Do you help providers assess the impacts of their clinical interventions?
- Do you provide data analytic support for clinical decision-making at the point of care?
- Do you seek to shift responsibility for data analytics to providers as they gain experience in the APM?
 - (Potentially – if so, does this shift in responsibility impact payment rates?)
- Why do you think that data analytic support was substantially responsible for the APM’s success?

Provider Supports: Technical assistance with practice transformation

- Can you explain the types of practice transformation support you offer providers and why it is responsible for improving cost and quality?
- Does your approach to practice transformation support vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you establish practice transformation programs, what steps did you take, and to what extent were providers involved in key decisions about how they should operate?
- Has your approach to practice transformation support changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to practice transformation support?
- Do your practice transformation programs include leadership training?

- Do your practice transformation programs include training on the APM's payment mechanisms and incentives?
- Do your practice transformation programs include financial and management training?
- Do your practice transformation programs facilitate peer-to-peer learning?
- Do you know whether practice transformation support delivers a return on investment?
- Why do you think that practice transformation support was substantially responsible for the APM's success?

Provider Supports: Supplemental staffing

- Can you explain the types of staff positions you help practices support, what types of functions they perform, and why it is responsible for improving cost and quality?
- Does your approach to staffing support vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you establish staffing support, what steps did you take, and to what extent were providers involved in key decisions about how to structure support programs?
- Has your approach to staffing support changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to staffing support?
- Are supplemental staff centrally located or embedded in provider organizations?
- How do you finance staffing support for providers?
- Do you know if your staffing support programs have delivered a return on investment?
- Why do you think that staffing support was substantially responsible for the APM's success?

Provider Supports: Effective learning collaboratives

- Can you describe the types of learning collaboratives that you support, the form they take, the topics that they cover, and why they are responsible for improving cost and quality?
- At what stage in the implementation process did you establish learning collaboratives, what steps did you take, and to what extent were providers involved in key decisions about how to structure support programs?
- Has your approach to learning collaboratives changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to learning collaboratives?
- Are your learning collaboratives geared toward a variety of providers, or do they focus on particular types of providers?
- What types of feedback have providers given you about their experience in the learning collaboratives?
- Are there incentives for providers to participate in learning collaboratives?
- Why do you think that learning collaboratives were substantially responsible for the APM's success?

Multipayer/multistakeholder collaboratives

- Can you describe the multipayer/multistakeholder collaborative in which you're involved and why it is responsible for improving cost and quality?
- At what point in the implementation process did you begin to participate in the multipayer/multistakeholder collaborative? What drove your decision to participate?
- Who is the convener, and which organizations participate?
- Which areas (e.g., quality measurement, financial incentives, data sharing) did the collaborative focus on and in which order?
- What types of processes were used to reach consensus among participants? On which topics was it most challenging to reach consensus?
- Did the collaborative face challenges securing commitments to participate and maintaining the engagement of participants?
 - (Potentially – if so, what were they, and how did you overcome them?)
- To what extent has multipayer/multistakeholder collaboration resulted in greater alignment of financial incentives? Which incentives in particular are used, and what are the advantages for providers?
- To what extent has multipayer/multistakeholder collaboration resulted in reduced reporting burden? Which reporting requirements in particular were reduced, and what are the advantages for providers?
- To what extent has multipayer/multistakeholder collaboration resulted in enhanced data sharing? Which types of data in particular are shared, and what are the advantages for providers?
- To what extent has multipayer/multistakeholder collaboration made it easier for providers to make the business case for population health management? Are you seeing evidence your providers are participating in aligned APMs offered by other payers?
- Which incentives are aligned across multiple payers that offer the same or similar APMs?
- How were plans able to reach agreement on a common set of incentives?
- Why do these particular incentives lead to beneficial changes in providers' practices?
- Why do you think that multipayer/multistakeholder collaboration was substantially responsible for the APM's success?

Scaling and sequencing of promising practices

- Can you describe how you scaled your APM and went about expanding it to larger numbers of providers? What types of challenges did you face?
- Which foundational activities and functions need to be in place before it's possible to increase the size and scope of the APM?
- What types of challenges did you encounter in the process of scaling the APM?
- On the sequence of implementation of promising practices, were certain practices implemented before others? Were all practices implemented at roughly the same time?

Provider Experience: Burden reduction

- Can you describe the efforts you undertook to reduce provider burden and why they are responsible for improving cost and quality?
- Does your approach to burden reduction vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you tackle provider burden, what steps did you take, and to what extent were providers involved in key decisions about how to reduce burden?
- Has your approach to burden reduction changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when trying to reduce provider burden?
- Which types of reporting were eliminated, and how did you identify superfluous reporting requirements?
- Why do you think that burden reduction was substantially responsible for the APM's success?

Provider Experience: Trust and relationship building

- Can you describe the approaches you used to build trust and relationships with providers participating in the APM and why it is responsible for improving cost and quality?
- Does your approach to provider relationships vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you establish processes to build trusting relationships with providers, and what steps did you take?
- Has your approach to provider relationships changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced in establishing trusting relationships with providers?
- Are providers given an opportunity to provide input on APM design and implementation, and has this input resulted in changes to the APM?
- To what extent do you use financial and other incentives to build trust with providers?
- Why do you think that trust and relationship building were substantially responsible for the APM's success?

Patient Experience: Accountability for patient experience

- Can you describe how the APM assesses patient experience and how/whether provider performance on the assessment impacts payment? Has this been responsible for improvements in cost and quality?
- Does your approach to assessing patient experience vary from provider to provider?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you establish assessments of patient experience, what steps did you take, and to what extent were providers involved in key decisions about the assessment?
- Has your approach to assessing patient experience changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)

- What were the most significant challenges you faced in establishing assessments of patient experience?
- Did you have to overcome resistance from providers who were concerned about reporting performance on patient experience or tying payments to this performance?
- Are you exploring other ways to evaluate patient experience in the APM? Ideally, how would you prefer to assess patient experience?
- Why do you think that accountability for patient experience was substantially responsible for the APM's success?

Patient Experience: Incentivize patient engagement and patient-centered care delivery

- Can you explain the approaches you take to encourage providers to engage patients in their care and to implement patient-centered delivery functions? Has this been responsible for improvements in cost and quality?
- Do you directly engage members/beneficiaries who are attributed to APMs?
 - (Potentially - if so, does your approach to patient engagement and activation differ for members in an APM versus those who are not)?
- Does your approach to incentivizing patient engagement vary among different patient populations?
 - (Potentially – if so, how?)
- At what stage in the implementation process did you tackle patient engagement, what steps did you take, and to what extent were providers involved in key decisions about how to enhance patient engagement?
- Has your approach to enhancing patient engagement changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to patient engagement?
- Do members/beneficiaries know that they are part of an APM?
- Are patients and/or patient advocates involved in key decisions about APM design and implementation?
- Do you enable shared decision-making among patients and providers? If so, how?
- What types of patient engagement do you consider most important for patients in APMs?
- Does the plan directly engage patients? If so, what approaches do you take, and what services do you provide?
- Why do you think that patient engagement and the adoption of patient-centered care delivery functions were substantially responsible for the APM's success?

Health Equity: Social support services encouraged or subsidized

- Can you explain your approach to reducing disparities and addressing social determinants of health? How and to what extent does your approach for reducing disparities for patients within an APM differ from the approach you use for members/beneficiaries who are not attributed to an APM?
- Does your approach to incentivizing patient engagement vary from provider to provider?
 - (Potentially – if so, how?)

- At what stage in the implementation process did you tackle health equity, what steps did you take, and to what extent were providers involved in key decisions about the approach?
- Has your approach to health equity changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing your approach to health disparities?
- What types of data and information do you collect about social determinants of health?
- How does the APM encourage providers to offer or establish linkages to social support services, and does it subsidize these types of activities?
- Does the plan play a direct role in subsidizing social support services or establishing linkages to community services, and what role do providers play?
- Why do you think that the availability of social support services was substantially responsible for the APM's success?

Possible Questions for Providers

Background

- Can you describe how your provider organization is structured?
- Do you consider yourself an urban or rural provider?
- Can you describe your patient population?
- How did [provider] decide to enter into the APM? How did you work with [payer] to structure the contracting terms, including the types of practice transformation supports you provide? Do you participate in APMs with other payers?
- What is the high-level payment structure and approach in your arrangement with [payer]? Is there any shared risk in the contract?
- What types of activities did you undertake to prepare to participate in the APM?

Leadership: Commitment to value-based care

- Can you describe your organizational leadership's vision for value-based care and how it impacts your organization's goals, priorities, and governance and incentive structures?
- How and why did your organization's leadership become committed to value-based care? Did this commitment precede your participation in the APM?
- To what extent was this commitment to value-based care influenced by interactions with [plan]?
- To what extent did this commitment reflect the values of individual clinicians within the organization?
- How does this current commitment to value-based care differ from previous strategies for delivering care?
- Has your leadership's vision for value-based care evolved over time?
 - (Potentially – if so, how did it change, and what prompted the change?)
- What were the most significant challenges your organization's leadership faced when instituting its commitment to value-based care?
- How does your organization's commitment to value-based care impact the day-to-day work of individual clinicians?

- Does your organization provide clinicians opportunities for leadership training and development?
- Why do you think that your organizational leadership's commitment to value-based care was substantially responsible for your success in the APM?

Infrastructure Investment: Technology investments

- Can you describe the types of investments you made in technology, such as enhanced EHRs with clinical decision-making support or data analytics?
- To what extent, and over what period of time, were these investments supported by [plan]?
- What steps have you taken to elicit input from clinicians about how to make technology investments?
- At what stage in the implementation process did you initiate investments in technology, and what steps did you take to plan for and make the investments?
- Has your technology investment strategy changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when making investments in technology?
- How were these investments financed, what types of practice transformations did they make possible, and did they deliver a return on investment?
- Why do you think that these technology investments were substantially responsible for your success in the APM?

Infrastructure Investment: Staffing support

- Can you describe the types of staff you hired or made use of to improve your performance in the APM?
- What types of functions did they perform, and what has been the impact on patient care and experience?
- To what extent, and over what period of time, was this additional staffing supported by [plan]?
- What steps have you taken to elicit input from clinicians about how to redesign your staffing model?
- At what stage in the implementation process did you hire additional staff, and what steps did you take to redesign and fill your staffing model?
- Has your staffing strategy changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when redesigning and filling your staffing model?
- How were these additional positions financed, what types of practice transformations did they make possible, and did they deliver a return on investment?
- Why do you think that additional staff support was substantially responsible for your success in the APM?

Population Health Management: Data analytics

- Can you describe the data analytic capabilities your organization uses to manage your patient population?
- To what extent, and over what period of time, were these capabilities supported by [plan]?
 - (Possibly – if so, were the plan’s tools useful, and what types of challenges did you experience using them?)
- At what stage in the implementation process did you start to establish data analytic capabilities, and what steps did you take to put them into place?
- Has your approach to data analytics changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when establishing data analytic capabilities?
- Has [plan] worked with other payers to report standardized data about patients, irrespective of which insurance they use?
- How do you stratify patients and identify the ones who are high risk? Do you also take steps to identify patients who are on the verge of becoming high risk?
- Do you work with patients to establish and monitor comprehensive care plans that entail care from multiple providers?
- What processes do you have in place to ensure that high-risk patients receive the additional support they require?
- What types of data architecture did your organization need to put into place to ensure that individual clinicians possessed the information they needed to effectively manage care?
- Did your organization have to work with EHR vendors to ensure that your medical records captured the information needed to effectively manage the health of your patient population?
 - (Possibly – if so, how were you able to effectively negotiate with vendors to establish the requisite fields in the EHR?)
- Have you worked with providers outside of your organization to share patient health records?
 - (Possibly – if so, what steps did you take to establish collaborative relationships and effective data exchange?)
- How did you secure the financing needed to establish data systems and analytic capabilities for population health management?
- Why do you think that data analytics was substantially responsible for your success in the APM?

Quality Improvement Initiatives: Improvement culture and continuous quality improvement

- Why and how does your organization exemplify a quality improvement culture?
- Which of your organization’s care variation reduction and quality improvement initiatives have contributed the most to improvements in care quality and patient outcomes? What was the impact of these initiatives on costs?
- Can you explain the steps you took to execute these initiatives? Did they precede your participation in the APM, or are they limited to patients attributed to your APM?
 - (Possibly – if so, how do they differ from improvement initiatives that take or took place outside the context of the APM?)
- Can you describe your efforts to reduce inappropriate care?

- How did you identify priorities for reducing inappropriate care; how do you designate certain types of care as inappropriate?
- How have inappropriate care reduction programs changed the way your organization delivers care?
- To what extent, and over what period of time, were these initiatives supported by [plan]?
- At what stage in the implementation process did you begin to implement a continuous quality improvement strategy, and what steps did you take to implement it?
- Has your staffing strategy changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when establishing a continuous quality improvement culture in your organization?
- What approaches do you use to engage individual clinicians in quality improvement initiatives?
- How do you prioritize areas and activities for quality improvement?
- Why do you think that your approach to continuous quality improvement was substantially responsible for your success in the APM?

Quality Improvement Initiatives: Measuring and monitoring

- Can you describe your approach to internal quality measurement and monitoring and how it relates to the quality measures used in the APM? Is this approach responsible for improvements in cost and quality?
- To what extent, and over what period of time, were these initiatives supported by [plan]?
- At what stage in the implementation process did you begin to develop a quality measurement and monitoring strategy, and what steps did you take to implement it?
- Has your approach to internal quality measurement and monitoring changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What types of measures do you use to monitor quality performance internally? How do you select measures and prioritize performance on some more than others?
- What types of data systems and data analytic capabilities were needed to execute your organization's measurement and monitoring strategy?
- What steps do you take to engage physicians about gaps in performance and how to remedy them?
- How burdensome is it for individual clinicians to report data that are used for the purpose of monitoring internal quality performance?
- Do you collect data on patient-reported outcomes and use these data to assess your organization's performance?
- Why do you think that your approach to quality measurement was substantially responsible for your success in the APM?

Effective care coordination

- Can you describe the efforts you undertook to improve care coordination and facilitate care transitions within your organization as well as with providers in different organizations? Is this approach responsible for improving cost and quality?
- How do you handle referrals and engage with specialists within the APM? Does this differ from the way you handle referrals and engage with specialists outside the APM?
- Can you describe your approach to behavioral health specialists and integration of primary care and behavioral health?
- Can you describe your approach to hospitals and integration of primary and acute care? Can you describe your approach to post-acute care facilities and integrating primary and post-acute care?
- To what extent, and over what period of time, were these initiatives supported by [plan]?
- At what stage in the implementation process did you begin to develop a care coordination strategy, and what steps did you take to implement it?
- Can you describe your particular approach to medication management?
 - (Possibly – if so, what role do clinical pharmacists play in your medication reconciliation strategy, and how do you assess medication reconciliation post discharge?)
- Has your approach to care coordination changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing and implementing a care coordination strategy?
- Have you hired additional staff to support care coordination functions?
 - (Possibly – if so, which types of staff have you hired, and what functions do they perform?)
- What role does health care data and analytics play in executing care coordination strategies?
- Which approaches have been effective for ensuring that clinicians on your team work effectively together?
- Does your care coordination strategy establish linkages (or provide directly) nonmedical services (e.g., housing, transportation, or nutrition)?
- Does your care coordination strategy focus on improving patient experience and engagement?
- Does your care coordination strategy focus on the right site of service?
- Does your care coordination strategy focus on referral and discharge procedures?
- Does your care coordination strategy focus on medication reconciliation?
- Does your care coordination strategy focus on reducing utilization and costs?
- Why do you think that your approach to care coordination was substantially responsible for your success in the APM?

Patient Engagement: Robust engagement activities

- Can you describe the efforts you undertook to engage patients to be more active participants in their care (e.g., by helping to develop and follow care plans, seeking care from high-value providers, taking advantage of necessary services, and more effectively engaging with the health care system)?

- Do you solicit and respond to patient input on how your organization implements delivery systems for population health?
 - (Possibly – if so, what process do you use?)
- Did your patient engagement initiatives lead to improvements in cost and quality?
- To what extent, and over what period of time, were your patient engagement activities supported by [plan]?
- At what stage in the implementation process did you begin to develop a patient engagement strategy, and what steps did you take to implement it?
- Has your approach to patient engagement changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing and implementing a patient engagement strategy?
- Of all your patient engagement initiatives, which ones had the most impact on health outcomes and patient engagement?
- Why do you think that your approach to patient engagement was substantially responsible for your success in the APM?

Patient Engagement: Measures of experience and adjustments based on feedback

- How do you assess patient experience?
- How have you used this information to adjust clinical work flows and other aspects of care delivery? Did these activities lead to cost and quality improvements?
- To what extent, and over what period of time, were these initiatives supported by [plan]?
- At what stage in the implementation process did you begin to develop a strategy to improve patient experience, and what steps did you take to implement it?
- Has your approach to improving patient experience changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing and implementing a strategy to improve patient experience?
- How have you collected data on patient experience, and what types of work flows and data architecture have you used to accomplish this?
- In an ideal world, how would you measure patient experience?
- Why do you think that your approach to improving patient experience was substantially responsible for your success in the APM?

Clinician Engagement: Use of cascading incentive payments

- Do financial incentives in the APM cascade down to individual clinicians? Why or why not?
- How does your organization determine which clinicians are eligible for incentive payments, and how does it distribute incentive payments to individual clinicians? Did incentive payments for individual clinicians lead to improvements in cost and quality?
- What steps have you taken to elicit input from clinicians about how to design incentive systems?
- At what stage in the implementation process did you begin to develop a strategy for incentivizing individual clinicians, and what steps did you take to implement it?
- Has your approach to incentivizing individual clinicians changed over time?

- (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing and implementing a strategy to incentivize individual clinicians?
- How do you ensure that cascading incentive payments fairly reward the performance of individual clinicians?
- How are the incentives for individual clinicians aligned with the incentives in the APM?
- What role has nonfinancial incentives played in improving the performance of individual clinicians?
- Why do you think that your approach to cascading incentive payments was substantially responsible for your success in the APM?

Clinician Engagement: Internally sharing performance data of individual clinicians

- Can you describe your approach to sharing performance data within clinical teams and establishing a feedback system for improving cost and quality performance? Did this approach lead to improvements in cost and quality?
- To what extent, and over what period of time, did [plan] support your efforts to design an internal feedback system?
- What steps have you taken to elicit input from clinicians about how to design the feedback system?
- At what stage in the implementation process did you begin to develop the feedback system, and what steps did you take to implement it?
- Has your approach to sharing performance data of individual clinicians changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when designing and implementing the internal feedback system?
- How did you select and prioritize quality, cost, and utilization measures used in the feedback system?
- Which types of health care data and analytics are needed to support your feedback system?
- What steps do you take to engage physicians about gaps in performance and how to remedy them?
- Why do you think that your internal feedback system was substantially responsible for your success in the APM?

Clinician Engagement: Effective learning collaboratives

- Can you describe the learning collaboratives that your organization offers and participates in? What format do they take, and what topics do they cover? Did these collaboratives lead to improvements in cost and quality?
- To what extent, and over what period of time, did [plan] support your efforts to establish or participate in learning collaboratives?
- What steps have you taken to elicit input from clinicians about how to design, operate, and participate in learning collaboratives?
- At what stage in the implementation process did you begin to establish or participate in learning collaboratives, and what steps did you take to do so?

- Has your approach to learning collaboratives changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when establishing or participating in learning collaboratives?
- What are some of the most valuable lessons your organization took away from learning collaboratives, and how have these lessons changed the way your organization delivers care?
- Why do you think that learning collaboratives were substantially responsible for your success in the APM?

Health Equity: Links to and/or offers of social support services

- Does your organization directly deliver social support services (e.g., transportation and housing) to your patients?
 - (Possibly – if so, which ones?)
- Do you establish linkages to social support services?
 - (Possibly – if so, how does your organization identify community partners, and how are these activities subsidized?)
- Did these efforts to address health disparities lead to improvements in cost and quality?
- To what extent, and over what period of time, did [plan] support your efforts to expand access to nonmedical services?
- What steps have you taken to elicit input from clinicians about how to design and operate programs to expand access to nonmedical services?
- At what stage in the implementation process did you begin to tackle health equity, and what steps did you take to expand access to nonmedical services?
- Has your approach to health equity changed over time?
 - (Potentially – if so, how did it change, and what prompted you to make a change?)
- What were the most significant challenges you faced when establishing expanded access to nonmedical services?
- Can you describe your approach to collecting information about social determinants of health and the steps you take to act on this information?
- Are there limitations to social support services that your organization is able to provide patients due to constraints imposed by regulations, the APM, or other funding sources?
- Why do you think that the availability of social support services was substantially responsible for your success in the APM?

Supplemental Provider Questions

- [For all providers]: What considerations did you take into account when deciding to participate in the APM?
- [For all providers]: Can you describe, at a high level, your interactions between you and [plan]? Are there areas where these interactions were particularly effective or improved, in your opinion?
- [For providers in multiple APMs]: Can you describe the challenges you've faced in working with multiple payers and participating in multiple APMs, including but not limited to, reporting data

for quality measurement? What has worked well, and where do you see the most opportunity to improve coordination and collaboration with multiple payers?

- [For providers with lots of experience]: Can you describe how your approach to health care delivery has evolved since you began participating in the APM and the approaches you took to achieve financial stability?
- [For providers in two-sided risk]: Can you explain the approaches you used to manage two-sided risk and whether those approaches differed from the ones you used to manage one-sided risk? How do you prepare to participate in a downside risk model?
- [For providers not in two-sided risk]: Are you planning on participating in downside-risk models in the future? If so, what type of preparation are you doing to prepare to participate in a downside-risk model?
- [For providers in multiple lines of business]: Can you describe your experience working in multiple lines of business (i.e., Medicare, commercial, Medicare Advantage, and Medicaid)? Are there notable barriers and facilitators associated with each line of business?

NOTICE

This technical data was produced for the U. S. Government under Contract Number HHSM-500-2012-00008I, and is subject to Federal Acquisition Regulation Clause 52.227-14, Rights in Data-General.

No other use other than that granted to the U. S. Government, or to those acting on behalf of the U. S. Government under that Clause is authorized without the express written permission of The MITRE Corporation.

For further information, please contact The MITRE Corporation, Contracts Management Office, 7515 Colshire Drive, McLean, VA 22102-7539, (703) 983-6000.

© 2019 The MITRE Corporation.