#### Introduction

The Health Care Payment Learning and Action Network's (LAN) goal is to bring together private payers, providers, employers, state partners, consumer groups, individual consumers, and other stakeholders to accelerate the transition to alternative payment models.

To measure the nation's progress, the LAN launched the National APM Data Collection Effort. This workbook will be used to collect health plan data according to the original APM Framework and line of business to be aggregated with other plan responses.

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Introducing the workbook and providing important instructions

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If you have any questions, please view the Frequently Asked Questions or email Andrea Caballero at <a href="mailto:acaballero@catalyze.org">acaballero@catalyze.org</a>

General Information				
Question		Information		
Please contact name e-mail and	Name			
phone for the health plan	E-mail			
respondent.	Phone			
What is the total number of	Comm			
members covered by the health	MA			
plan by line of business?	МСО			

Question	State
In which state(s) does the health	Alabama
plan have business? Please	Alaska
specify which line of business	Arizona
next to the state name.	Arkansas
(C- commercial, MA – Medicare	California
Advantage, MCO – Medicaid)	Colorado
,	Connecticut
	Delaware
	Florida
	Georgia
	Hawaii
	Idaho
	Illinois
	Indiana
	Iowa
	Kansas
	Kentucky
	Louisiana
	Maine
	Maryland
	Massachusetts
	Michigan
	Minnesota
	Mississippi
	Missouri
	Montana
	Nebraska
	Nevada
	New Hampshire
	New Jersey
	New Mexico
	New York
	North Carolina
	North Dakota
	Ohio

Question	State
In which state(s) does the health	Oklahoma
plan have business? Please	Oregon
specify which line of business	Pennsylvania
next to the state name.	Puerto Rico
(C- commercial, MA – Medicare	Rhode Island
Advantage, MCO – Medicaid)	South Carolina
	South Dakota
	Tennessee
	Texas
	Utah
	Vermont
	Virginia
	Washington
	West Virginia
	Wisconsin
	Wyoming

Question		Information
What is the plan's total health	Comm	
Care spend (in-and out of	MA	
network) by line of business?	MCO	
Please specify if you are using CY		
2016 data or most recent 12		
months. Please specify if the time		
Reporting differs by line of		
Business		
If you are using most recent 12		
months, please specify the 12		
month		
Does your submission include		
the prescription drug claims data	Comm	
under the pharmacy benefit in		
denominator (total spend)?If yes,	MA	
what percent of the pharmacy		
benefit spend is included?	MCO	
Does your submission include		
behavioral health claims data		
In the denominator (total spend)?		
If yes, what percent of the		
behavioral health spend is		
included?		
Please list other assumptions,		
qualifications, considerations, or		
limitations related to the data		
submission.		

Question		Information
How many hours did it take your	Commercial	
Organization to complete this	Hours:	
Survey by line of business? Please	Medicare	
Report your response in?	Advantage	
	Hours:	
	Medicaid	
	Hours:	

#### Commercial Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2016 or most recent 12 months, as specified.

The goal is NOT to gather information on a projection or estimation of where the plan would be if their contracts were in place the entire calendar year. Rather it is based on what the plan actually paid in claims for the specified time period.

#### Methods

The metrics should report actual dollars paid through APMs CY 2016 or during the specified time period. For example, if a provider is paid \$120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2016, the payments the provider received from January 1, 2016 through June 31, 2016 (\$60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2016 through December 31, 2016 (\$60,000) would be reported as shared savings, if the reporting period is for CY 2016. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2016, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received \$300 (a combination of \$285 base payment plus \$15 in shared savings), which, if multiplied by 365 (annualized), would be reported as \$109,500 in shared savings CY 2016. An unacceptable approach is counting all of dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting \$120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

Plans should report the total dollars paid, which includes the base payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc.

To the extent payment to a provider includes multiple APMs, the plans should put the dollars in the dominant APM. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

#### Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers' CY 2016 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on members attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

### Alternative Payment Model Framework – Category 1 (Metrics below apply to total dollars paid for commercial members. Metrics are NOT linked to quality)

#	Numerator	Numerator	Denominator	Denominator	Metric	Metric
		Value		Value		Value
1	NA	NA	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Denominator to inform the metrics below	NA
2	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2016 or most recent 12 months.	0

### Alternative Payment Model Framework—Category 2 (All methods below are linked to quality).

#	Numerator	Numerator	Denominator	Denominator	Metric	Metric
		Value		Value		Value
3	Dollars paid for foundational spending to improve care (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2016 or most recent 12 months.	NA
4	Total dollars paid to providers through FFS plus P4P payments (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2016 or most recent 12 months.  * CPR historic metric - trend.	0
5	Total dollars paid in Category 2 in CY 2016 or most recent 12 months.		Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	0

# Alternative Payment Model Framework – Category 3 (All models below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
6	Total dollars paid to providers through FFS-based shared-savings (linked to quality) payments in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in CY 2016 or most recent 12 months	NA

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
7	Total dollars paid to providers through FFS-based shared-risk (linked to quality) payments in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in shared- risk programs: Percent of total dollars paid through FFS-based shared- risk (linked to quality) payments in CY 2016 or most recent 12 months.	0
8	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2016 or most recent 12 months.	0
9	Total dollars paid to providers through population-based payments that are not condition-specific (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Population-based payments to providers that are not condition-specific and linked to quality: Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in CY 2016 or most recent 12 months.	0
10	Total dollars paid in Category 3 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	0

# Alternative Payment Model Framework – Category 4 (All models below are linked to quality).

#	Numerator	Numerator	Denominator	Denominator	Metric	Metric
		Value		Value		Value
11	Total dollars	0	Total dollars paid	0	Population-based	NA
	paid to		to providers (in		payments for	
	providers		and out of		conditions (linked	
	through		network) for		to quality):	
	population-		commercial		Percent of total	
	based		members in CY		dollars paid	
	payments for		2016 or most		through	
	conditions		recent 12 months.		condition-specific	
	(linked to				population-based	
	quality) in CY				payments linked	
	2016 or most				to quality in CY	
	recent 12				2016 or most	
	months.				recent 12 months.	
12	Total dollars	0	Total dollars paid	0	Dollars in	0
	paid to		to providers (in		condition-specific	
	providers		and out of		bundled/episode	
	through		network) for		payment	
	condition-		commercial		programs (linked	
	specific,		members in CY		to quality):	
	bundled/episod		2016 or most		Percent of total	
	e payments		recent 12 months.		dollars paid	
	(linked to				through	
	quality) in CY				condition-specific	
	2016 or most				bundled/episode-	
	recent 12				based payments	
	months.				linked to quality in	
					CY 2016 or most	
					recent 12 months.	

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
13	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments in CY 2016 or most recent 12 months.	0
14	Total dollars paid in Category 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	0

### Aggregated Metrics (Comparison between Category 1 and Categories 2-4)

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
15	NA	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Denominator to inform the metrics below	NA

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
16	Total dollars paid to providers through legacy payments (including FFS without a quality	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months.	0
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2016 or most recent 12 months.	0

#### Medicare Advantage Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2016 or most recent 12 months, as specified.

The goal is NOT to gather information on a projection or estimation of where the plan would be if their contracts were in place the entire calendar year. Rather it is based on what the plan actually paid in claims for the specified time period.

#### Methods

he metrics should report actual dollars paid through APMs CY 2016 or during the specified time period. For example, if a provider is paid \$120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2016, the payments the provider received from January 1, 2016 through June 31, 2016 (\$60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2016 through December 31, 2016 (\$60,000) would be reported as shared savings, if the reporting period is for CY 2016. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2016, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received \$300 (a combination of \$285 base payment plus \$15 in shared savings), which, if multiplied by 365 (annualized), would be reported as \$109,500 in shared savings CY 2016. An unacceptable approach is counting all of dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting \$120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

Plans should report the total dollars paid, which includes the base payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc.

To the extent payment to a provider includes multiple APMs, the plans should put the dollars in the dominant APM. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

#### **Metrics**

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2016 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on members attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

## Alternative Payment Model Framework – Category 1 (Metrics below apply to total dollars paid for commercial members. Metrics are NOT linked to quality)

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
1	NA	NA	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Denominator to inform the metrics below	NA
2	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2016 or most recent 12 months.	0

## Alternative Payment Model Framework – Category 2 (All methods below are linked to quality).

#	Numerator	Numerator	Denominator	Denominator	Metric	Metric
		Value		Value		Value
3	Dollars paid for	0	Total dollars paid	0	Foundational	NA
	foundational		to providers (in		spending to	
	spending to		and out of		improve care:	
	improve care		network) for		Percent of dollars	
	(linked to		commercial		paid for	
	quality) in CY		members in CY		foundational	
	2016 or most		2016 or most		spending to	
	recent 12		recent 12 months.		improve care in CY	
	months.				2016 or most	
					recent 12 months.	
4	Total dollars paid	0	Total dollars paid	0	Dollars in P4P	0
	to providers		to providers (in		programs: Percent	
	through FFS plus		and out of		of total dollars	
	P4P payments		network) for		paid through FFS	
	(linked to		commercial		plus P4P (linked to	
	quality) in CY		members in CY		quality) payments	
	2016 or most		2016 or most		in CY 2016 or most	
	recent 12		recent 12 months.		recent 12 months.	
	months.				* CPR historic	
					metric - trend.	
5	Total dollars paid		Total dollars paid	0	Payment Reform -	0
	in Category 2 in		to providers (in		APMs built on FFS	
	CY 2016 or most		and out of		linked to quality:	
	recent 12		network) for		Percent of total	
	months.		commercial		dollars paid in	
			members in CY		Category 2.	
			2016 or most			
			recent 12 months.			

### Alternative Payment Model Framework – Category 3 (All models below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
6	Total dollars paid to providers through FFS- based shared- savings (linked to quality) payments in CY 2016 or most	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in shared- savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in CY	NA

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
	recent 12	value		value	2016 or most	-value
	months.				recent 12 months	
7	Total dollars	0	Total dollars	0	Dollars in shared-	0
	paid to providers		paid to		risk programs:	
	through FFS-		providers (in and		Percent of total	
	based shared-		out of network)		dollars paid	
	risk (linked to		for commercial		through FFS-based	
	quality)		members in CY		shared-risk (linked	
	payments in CY		2016 or most		to quality)	
	2016 or most		recent 12		payments in CY	
	recent 12		months.		2016 or most	
	months.	_		_	recent 12 months.	_
8	Total dollars	0	Total dollars	0	Dollars in	0
	paid to providers		paid to		procedure-based	
	through procedure-		providers (in and out of network)		bundled/episode	
	based		for commercial		payments (linked to quality)	
	bundled/episode		members in CY		programs: Percent	
	payments		2016 or most		of total dollars paid	
	(linked to		recent 12		through	
	quality)		months.		procedure-based	
	programs in CY				bundled/episode	
	2016 or most				payments in CY	
	recent 12				2016 or most	
	months.				recent 12 months.	
9	Total dollars	0	Total dollars	0	Population-based	0
	paid to providers		paid to		payments to	
	through		providers (in and		providers that are	
	population-		out of network)		not condition-	
	based payments		for commercial		specific and linked	
	that are not		members in CY		to quality: Percent	
	condition-		2016 or most		of total dollars paid	
	specific (linked		recent 12		through	
	to quality) in CY 2016 or most		months.		population-based (linked to quality)	
	recent 12				payments that are	
	months.				not condition-	
					specific in CY 2016	
					or most recent 12	
					months.	
10	Total dollars	0	Total dollars paid	0	Payment Reform -	0
	paid in Category		to providers (in		APMs built on FFS	
	3 in CY 2016 or		and out of		architecture:	
	most recent 12		network) for		Percent of total	
	months.		commercial members in CY			
			members in Cr			

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
			2016 or most recent 12 months.		dollars paid in Category 3.	

# Alternative Payment Model Framework – Category 4 (All models below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
11	Total dollars	0	Total dollars paid	0	Population-based	NA
	paid to		to providers (in		payments for	
	providers		and out of		conditions (linked	
	through		network) for		to quality):	
	population-		commercial		Percent of total	
	based		members in CY		dollars paid	
	payments for		2016 or most		through	
	conditions		recent 12 months.		condition-specific	
	(linked to				population-based	
	quality) in CY				payments linked	
	2016 or most				to quality in CY	
	recent 12				2016 or most	
	months.				recent 12 months.	
12	Total dollars	0	Total dollars paid	0	Dollars in	0
	paid to		to providers (in		condition-specific	
	providers		and out of		bundled/episode	
	through		network) for		payment	
	condition-		commercial		programs (linked	
	specific,		members in CY		to quality):	
	bundled/episod		2016 or most		Percent of total	
	e payments		recent 12 months.		dollars paid	
	(linked to				through	
	quality) in CY				condition-specific	
	2016 or most				bundled/episode-	
	recent 12				based payments	
	months.				linked to quality in	
					CY 2016 or most	
					recent 12 months.	

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
13	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments in CY 2016 or most recent 12 months.	0
14	Total dollars paid in Category 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	0

### Aggregated Metrics (Comparison between Category 1 and Categories 2-4)

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
15	NA	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Denominator to inform the metrics below	NA

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
16	Total dollars paid to providers through legacy payments (including FFS without a quality	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months.	0
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2016 or most recent 12 months.	0

#### **Medicaid Metrics**

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2016 or most recent 12 months, as specified.

The goal is NOT to gather information on a projection or estimation of where the plan would be if their contracts were in place the entire calendar year. Rather it is based on what the plan actually paid in claims for the specified time period.

#### Methods

The metrics should report actual dollars paid through APMs CY 2016 or during the specified time period. For example, if a provider is paid \$120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2016, the payments the provider received from January 1, 2016 through June 31, 2016 (\$60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2016 through December 31, 2016 (\$60,000) would be reported as shared savings, if the reporting period is for CY 2016. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2016, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received \$300 (a combination of \$285 base payment plus \$15 in shared savings), which, if multiplied by 365 (annualized), would be reported as \$109,500 in shared savings CY 2016. An unacceptable approach is counting all of dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting \$120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

Plans should report the total dollars paid, which includes the base payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc.

To the extent payment to a provider includes multiple APMs, the plans should put the dollars in the dominant APM. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

#### **Metrics**

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2016 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on beneficiaries attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

## Alternative Payment Model Framework – Category 1 (Metrics below apply to total dollars paid for commercial members. Metrics are NOT linked to quality)

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
1	NA	NA	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Denominator to inform the metrics below	NA
2	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2016 or most recent 12 months.	0

### Alternative Payment Model Framework – Category 2 (All methods below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
3	Dollars paid for foundational spending to improve care (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2016 or most recent 12 months.	NA
4	Total dollars paid to providers through FFS plus P4P payments (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2016 or most recent 12 months. * CPR historic metric - trend.	0
5	Total dollars paid in Category 2 in CY 2016 or most recent 12 months.		Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	0

### Alternative Payment Model Framework – Category 3 (All models below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
6	Total dollars paid to providers through FFS- based shared- savings (linked to quality) payments in CY 2016 or most	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in shared- savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in CY	NA

#	Numerator	Numerator	Denominator	Denominator	Metric	Metric
	1.45	Value		Value	2016	Value
	recent 12				2016 or most	
	months.	0	Takal dallana naid	0	recent 12 months	0
7	Total dollars	0	Total dollars paid	0	Dollars in shared-	0
	paid to providers through FFS-		to providers (in and out of		risk programs: Percent of total	
	based shared-		network) for		dollars paid	
	risk (linked to		commercial		through FFS-based	
	quality)		members in CY		shared-risk (linked	
	payments in CY		2016 or most		to quality)	
	2016 or most		recent 12		payments in CY	
	recent 12		months.		2016 or most	
	months.				recent 12 months.	
8	Total dollars	0	Total dollars paid	0	Dollars in	0
	paid to providers		to providers (in		procedure-based	
	through		and out of		bundled/episode	
	procedure-		network) for		payments (linked	
	based		commercial		to quality)	
	bundled/episode		members in CY		programs: Percent	
	payments (linked to		2016 or most recent 12		of total dollars paid	
	quality)		months.		through procedure-based	
	programs in CY		months.		bundled/episode	
	2016 or most				payments in CY	
	recent 12				2016 or most	
	months.				recent 12 months.	
9	Total dollars	0	Total dollars paid	0	Population-based	0
	paid to providers		to providers (in		payments to	
	through		and out of		providers that are	
	population-		network) for		not condition- specific and linked to	
	based payments		commercial		quality: Percent of	
	that are not		members in CY		total dollars paid	
	condition-		2016 or most		through population-	
	specific (linked		recent 12		based (linked to	
	to quality) in CY 2016 or most		months.		quality) payments	
	recent 12				that are not condition-specific in	
	months.				CY 2016 or most	
L					recent 12 months.	
10	Total dollars	0	Total dollars paid	0	Payment Reform -	0
	paid in Category		to providers (in		APMs built on FFS	
	3 in CY 2016 or		and out of		architecture:	
	most recent 12		network) for commercial		Percent of total	
	months.		members in CY		dollars paid in	
			2016 or most		Category 3.	
			recent 12 months.			

# Alternative Payment Model Framework – Category 4 (All models below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
11	Total dollars paid to providers through population- based payments for conditions (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2016 or most recent 12 months.	NA
12	Total dollars paid to providers through condition- specific, bundled/episod e payments (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in condition-specific bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episodebased payments linked to quality in CY 2016 or most recent 12 months.	0

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
13	Total dollars paid to providers through full or percent of premium population- based payments (linked to quality) in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments in CY 2016 or most recent 12 months.	0
14	Total dollars paid in Category 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	0

### Aggregated Metrics (Comparison between Category 1 and Categories 2-4)

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
15	NA	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Denominator to inform the metrics below	NA

#	Numerator	Numerator Value	Denominator	Denominator Value	Metric	Metric Value
16	Total dollars paid to providers through legacy payments (including FFS without a quality	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months.	0
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for commercial members in CY 2016 or most recent 12 months.	0	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2016 or most recent 12 months.	0

	Cross-Checking
Questions	Responses
For the look back metrics only,	Select all that apply
what payment models were in	Foundational spending to improve care
effect during specified the	FFS plus Pay for Performance
period of reporting? Please	FFS-based Shared Savings
specify the line of business	FFS-based Shared Risk
(Comm, MA, MCO).	Procedure-based Bundled/Episode Payments
	Population-based Payments not condition-specific
	Population-based Payments condition-specific
	Condition-Specific Bundled/Episode Payments
	Full or Percent of Premium Population-based Payment
For each program Identified	Launch date (Mont/Year in column B)
in the prior question, Indicate	Foundational spending to improve care
When the program was	FFS plus Pay for Performance
launched. Please specify the	FFS-based Shared Savings
line of business	FFS-based Shared Risk
(Comm, MA, MCO).	Procedure-based Bundled/Episode Payments
	Population-based Payments not condition-specific
	Population-based Payments condition-specific
	Condition-Specific Bundled/Episode Payments
	Full or Percent of Premium Population-based Payment
For each program identified	Indicate Pilot, Expansion, or Fully Implemented*in
In the first question,	Foundational spending to improve care
describe its current stage	FFS plus Pay for Performance
Of implementation	FFS-based Shared Savings
(Pilot, Expansion, Fully	FFS-based Shared Risk
Implemented) *. Please	Procedure-based Bundled/Episode Payments
specify the line of business	Population-based Payments not condition-specific
(Comm, MA, MCO)	Population-based Payments condition-specific
	Condition-Specific Bundled/Episode Payments
	Full or Percent of Premium Population-based Payment

<sup>\*</sup>Pilot mode (e.g. only available for a subset of members and/or providers)

<sup>\*</sup>Expansion mode (e.g. passed initial pilot stage)

<sup>\*</sup>Fully implemented (e.g. generally available)

### Definitions per the original APM Framework

Note: The revised APM Framework will be published in Summer 2017. For purposes of 2017 measurement, please refer to the original category definitions below.

Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods that use
	financial incentives to promote or leverage
	greater value - including higher quality care
	at lower costs - for patients, purchasers,
	payers and providers. This definition is
	specific to this exercise. If you are interested
	in MACRA's definition, please reference
	MACRA for more details.
	APM Framework White Paper
	MACRA Website
Category 1	Fee-for-service with no link to quality. These
	payments utilize traditional FFS payments
	that are <u>not</u> adjusted to account for
	infrastructure investments, provider
	reporting of quality data, for provider
	performance on cost and quality metrics.
	Diagnosis-related groups (DRGs) that are not
	linked to quality are in Category 1.
Category 2	Fee-for-service linked to quality. These
	payments utilize traditional FFS payments,
	but are subsequently adjusted based on
	infrastructure investments to improve care
	or clinical services, whether providers report
	quality data, or how well they perform on
	cost and quality metrics.

Terms	Definitions
Category 3	Alternative payment methods (APMs) built
	on fee-for-service architecture. These
	payments are based on FFS architecture,
	while providing mechanisms for effective
	management of a set of procedures, an
	episode of care, or all health services
	provided for individuals. In addition to taking
	quality considerations into account,
	payments are based on cost performance
	against a target, irrespective of how the
	financial benchmark is established, updated,
	or adjusted. Providers that meet their cost
	and quality targets are eligible for shared
	savings, and those that do not may be held
	financially accountable.
Category 4	Population-based payment. These payments
	are structured in a manner that encourages
	providers to deliver well-coordinated, high
	quality person level care within a defined or
	overall budget. This holds providers
	accountable for meeting quality and,
	increasingly, person centered care goals for a
	population of patients or members.  Payments are intended to cover a wide range
	of preventive health, health maintenance,
	and health improvement services, among
	other items. These payments will likely
	require care delivery systems to establish
	teams of health professionals to provide
	enhanced access and coordinated care.
Commercial members/	Health plan enrollees or plan participants.
Medicare Advantage members/	reality plan emonees of plan participants.
Medicaid beneficiaries	
Tricultura Schichicianics	

Terms	Definitions
Condition-specific bundled/episode	A single payment to providers and/or health
payments	care facilities for all services related to a
	specific condition (e.g. diabetes). The
	payment considers the quality, costs, and
	outcomes for a patient-centered course of
	care over a longer time period and across
	care settings. Providers assume financial risk
	for the cost of services for a particular
	condition, as well as costs associated with
	preventable complications. [APM Framework
	Category 4A]
CY 2016 or most recent 12 months	Calendar year 2016 or the most current 12-
	month period for which the health plan can
	report payment information. This is the
	reporting period for which the health plan
	should report all of its "actual" spend data - a
Diagnosis valetad gravus (DDCs)	retrospective "look back."
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system
	that uses information about patient
	diagnoses and selected procedures to identify patients that are expected to have
	similar costs during a hospital stay - a form of
	case rate for a hospitalization. Each DRG is
	assigned a weight that reflects the relative
	cost of caring for patients in that category
	relative to other categories and is then
	multiplied by a conversion factor to establish
	payment rates.
Fee-for-service	Providers receive a negotiated or payer-
	specified payment rate for every unit of
	service they deliver without regard to quality,
	outcomes or efficiency. [APM Framework
	Category 1]
Foundational spending	Includes but is not limited to payments to
	improve care delivery such as outreach and
	care coordination/management; after-hour
	availability; patient communication
	enhancements; health IT infrastructure use.
	May come in the form of care/case
	management fees, medical home payments,
	infrastructure payments, meaningful use
	payments and/or per-episode fees for
	specialists. [APM Framework Category <b>2A</b> ]

Terms	Definitions
Full or percent of premium population-	A fixed dollar payment to providers for all the
based payments	care that a patient population may receive in
	a given time period, such as a month or year,
	(e.g. inpatient, outpatient, specialists, out-of-
	network, etc.) with payment adjustments
	based on measured performance and patient
	risk. [APM Framework Category 4B]
Legacy payments	Payments that utilize traditional payments
	and are not adjusted to account for
	infrastructure investments, provider
	reporting of quality data, or for provider
	performance on cost and quality metrics. This
	can include fee-for-service, diagnosis-related
	groups (DRGs) and per diems. [APM
	Framework Category 1].
Linked to quality	Payments that are set or adjusted based on
	evidence that providers meet a quality
	standards or improve care or clinical services,
	including for providers who report quality
	data, or providers who meet threshold on
	cost and quality metrics. The APM
	Framework does not specify which quality
	measures qualify for a payment method to
	be "linked to quality."
Pay for performance	The use of incentives (usually financial) to
	providers to achieve improved performance
	by increasing the quality of care and/or
	reducing costs. Incentives are typically paid
	on top of a base payment, such as fee-for-
	service or population-based payment. In
	some cases, if providers do not meet quality
	of care targets, their base payment is
	adjusted downward the subsequent year.
	[APM Framework Categories 2C & 2D].
Population-based payment for conditions	A per member per month (PMPM) payment
	to providers for inpatient and outpatient care
	that a patient population may receive for a
	particular condition in a given time period,
	such as a month or year, including inpatient
	care and facility fees. [APM Framework
	Category 4A].

Terms	Definitions
Population-based payment not condition-	A per member per month (PMPM) payment
specific	to providers for outpatient or professional
	services that a patient population may
	receive in a given time period, such as a
	month or year, not including inpatient care or
	facility fees. The services for which the
	payment provides coverage is predefined and
	could be, for example, primary care services
	or professional services that are not specific
	to any particular condition. [APM Framework
	Category 3B].
Procedure-based bundled/episode payment	Setting a single price for all services to
	providers and/or health care facilities for all
	services related to a specific procedure (e.g.
	hip replacement). The payment is designed
	to improve value and outcomes by using
	quality metrics for provider accountability.  Providers assume financial risk for the cost of
	services for a particular procedure and
	related services, as well as costs associated
	with preventable complications. [APM
	Framework Categories <b>3A</b> & <b>3B</b> ].
Provider	For the purposes of this workbook, provider
	includes all providers for which there is
	health care spending. For the purposes of
	reporting APMs, this includes medical,
	behavioral, pharmacy, and DME spending to
	the greatest extent possible.
Shared risk	A payment arrangement that allows
	providers to share in a portion of any savings
	they generate as compared to a set target for
	spending, but also puts them at financial risk
	for any overspending. Shared risk provides
	both an upside and downside financial
	incentive for providers or provider entities to
	reduce unnecessary spending for a defined
	population of patients or an episode of care,
	and to meet quality targets.

Terms	Definitions
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in calendar year (CY) 2016 or most recent 12 months.