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 (APMs).

To measure the nation's progress, the LAN launched the National APM Data Collection Effort in 2016. This workbook will be used to collect health plan data according to the Refreshed APM Framework, which was revised in January 2017, and line of business to be aggregated with other plan responses.

Refreshed APM Framework Overview

Contents

If you have any questions, please view the Frequently Asked Questions or email Andrea Caballero at acaballero@catalyze.org

General Information

Questions	Responses	
Provide contact name, email and phone for the health plan respondent.	Name	
	Email	
	Phone	
What is the total number of members covered by the health plan by line of business?	Comm	
	MA	
	MCO	
In which state(s) does the health plan have business? Please specify which line of business next to the state name. (C - commercial, MA - Medicare Advantage, MCO - Medicaid)		Alabama
		Alaska
		Arizona
		Arkansas
		California
		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
		Oklahoma
		Oregon
		Pennsylvania
		Puerto Rico
		Rhode Island
		South Carolina
		South Dakota
		Tennessee
		Texas
		Utah
		Vermont
		Virginia
		Washington
		West Virginia
		Wisconsin
		Wyoming
What is the plan's total health care spend (in- and out-of-network) by line of business?	Comm	
	MA	
	MCO	
Please specify if you are using CY 2017 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 period.		
Does your submission include prescription drug claims data under the pharmacy benefit in the denominator (total spend)? If yes, what percent of the pharmacy benefit spend is included?	Comm	
	MA	
	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?	Comm	
	MA	
	MCO	
Please list other assumptions, qualifications, considerations, or limitations related to the data submission.		
How many hours did it take your organization to complete this survey by line of business? Please report your response in hours.	Comm	
	MA	
	MCO	

Commercial Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2017 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 2017 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, 2017, the payments the provider received from January 1, 2017 through June 31, 2017 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2017 through December 31, 2017 ($60,000) would be reported as shared savings, if the reporting period is for CY 2017. 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, 2017, **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 2017. An unacceptable approach is counting all of the 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, meaning the most advanced method. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2017 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.

#	Numerator/Denominator	Dollar Value	Description of Metric	Metric Calculation
1	Total dollars paid to providers (in and out of network) for commercial members in CY 2017 or most recent 12 months.	$0.00	Denominator to inform the metrics below	NA
Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for commercial members. Metrics are NOT linked to quality)				
2	Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2017 or most recent 12 months.	$0.00	Dollars under legacy payments (including Fee-for-Service, Diagnosis-Related Groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2017 or most recent 12 months.	#DIV/0!
Alternative Payment Model Framework - Category 2 (Metrics below apply to total dollars paid for commercial members. Metrics are linked to quality).				
3	Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2017 or most recent 12 months.	#DIV/0!

4	Total dollars paid to providers through f**ee-for-Service plus pay-for-performance** payments (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2017 or most recent 12 months. * CPR historic metric - trend.	#DIV/0!
5	Total dollars paid in **Category 2** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (Metrics below apply to total dollars paid for commercial members. Metrics are linked to quality)				
6	Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2017 or most recent 12 months.	#DIV/0!
7	Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2017 or most recent 12 months.	#DIV/0!
8	Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in FFS-based shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in CY 2017 or most recent 12 months.	#DIV/0!

9	Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2017 or most recent 12 months.	$0.00	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2017 or most recent 12 months.	#DIV/0!
10	Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2017 or most recent 12 months.	$0.00	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 2017 or most recent 12 months.	#DIV/0!
11	Total dollars paid in **Category 3** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!
Alternative Payment Model Framework - Category 4 (Metrics below apply to total dollars paid for commercial members. Metrics are linked to quality)				
12	Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars under legacy payments (including Fee-for-Service, Diagnosis-Related Groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2017 or most recent 12 months.	#DIV/0!

13	Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars in condition-specific bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode-based payments linked to quality in CY 2017 or most recent 12 months.	#DIV/0!
14	Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2017 or most recent 12 months.	$0.00	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 2017 or most recent 12 months.	#DIV/0!
15	Total dollars paid to providers through **integrated finance and delivery** programs (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs in CY 2017 or most recent 12 months.	#DIV/0!
16	Total dollars paid in **Category 4** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!
Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				
17	Total dollars paid to providers through **legacy payments** in CY 2017 or most recent 12 months.	$0.00	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component and DRGs).	#DIV/0!

18	Total dollars paid to providers through **payment reforms in Categories 2-4** in CY 2017 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2017 or most recent 12 months.	#DIV/0!
19	Total dollars paid to providers through **payment reforms in Categories 3 and 4** in CY 2017 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2017 or most recent 12 months.	#DIV/0!

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating and Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
Aggregated Metrics (Comparison between Category 1 and Categories 2-4)								
16	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2015 or most recent 12 months.	Category 1, Q2, Cell C4	Total dollars paid to providers for commercial members in CY 2015 or most recent 12 months.	Err:509	Roll-up metric showing the percentage of payments that are still based on legacy payments.	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component and DRGs).		
17	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2015 or most recent 12 months.	Category 2, Q5, cell C5 + Category 3, Q11, cell C8 + Category 4, Q16, cell C7	Total dollars paid to providers for commercial members in CY 2015 or most recent 12 months.	Err:509	Roll-up metric based upon the distribution of payment reform models.	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2015 or most recent 12 months.		

18	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2015 or most recent 12 months.	Category 3, Q11, cell C8 + Category 4, Q16, cell C7	Total dollars paid to providers for commercial members in CY 2015 or most recent 12 months.	Err:509	Roll-up metric based upon the distribution of payment reform models.	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2015 or most recent 12 months.		

Medicare Advantage Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2017 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 2017 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, 2017, the payments the provider received from January 1, 2017 through June 31, 2017 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2017 through December 31, 2017 ($60,000) would be reported as shared savings, if the reporting period is for CY 2017. 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, 2017, **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 2017. An unacceptable approach is counting all of the 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, meaning the most advanced method. For example, if a provider has a shared savings contract with a health plan and the provider is also eligible for performance bonuses for meeting quality measures (P4P), the health plan would report the FFS claims, shared savings payments (if any), and the P4P dollars in the shared savings subcategory (Category 3).

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2017 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.

#	Numerator/Denominator	Dollar Value	Description of Metric	Metric Calculation

1	Total dollars paid to providers (in and out of network) for Medicare Advantage members in CY 2017 or most recent 12 months.	$0.00	Denominator to inform the metrics below	NA
Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for MA members. Metrics are NOT linked to quality)				
2	Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2017 or most recent 12 months.	$0.00	Dollars under legacy payments (including Fee-for-Service, Diagnosis-Related Groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2017 or most recent 12 months.	#DIV/0!
Alternative Payment Model Framework - Category 2 (Metrics below apply to total dollars paid for MA members. Metrics are linked to quality).				
3	Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2017 or most recent 12 months.	#DIV/0!
4	Total dollars paid to providers through f**ee-for-Service plus pay-for-performance** payments (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2017 or most recent 12 months. * CPR historic metric - trend.	#DIV/0!
5	Total dollars paid in **Category 2** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (Metrics below apply to total dollars paid for MA members. Metrics are linked to quality)				

6	Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2017 or most recent 12 months.	#DIV/0!
7	Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2017 or most recent 12 months.	#DIV/0!
8	Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in FFS-based shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in CY 2017 or most recent 12 months.	#DIV/0!
9	Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2017 or most recent 12 months.	$0.00	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2017 or most recent 12 months.	#DIV/0!
10	Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2017 or most recent 12 months.	$0.00	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 2017 or most recent 12 months.	#DIV/0!

11	Total dollars paid in **Category 3** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!
Alternative Payment Model Framework - Category 4 (Metrics below apply to total dollars paid for MA members. Metrics are linked to quality)				
12	Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars under legacy payments (including Fee-for-Service, Diagnosis-Related Groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2017 or most recent 12 months.	#DIV/0!
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16	Total dollars paid in **Category 4** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!
Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				
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18	Total dollars paid to providers through **payment reforms in Categories 2-4** in CY 2017 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2017 or most recent 12 months.	#DIV/0!
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Medicaid Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2017 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 2017 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, 2017, the payments the provider received from January 1, 2017 through June 31, 2017 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2017 through December 31, 2017 ($60,000) would be reported as shared savings, if the reporting period is for CY 2017. 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, 2017, **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 2017. An unacceptable approach is counting all of the 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.

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Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2017 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.

#	Numerator/Denominator	Dollar Value	Description of Metric	Metric Calculation
1	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2017 or most recent 12 months.	$0.00	Denominator to inform the metrics below	NA
Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are NOT linked to quality)				
2	Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2017 or most recent 12 months.	$0.00	Dollars under legacy payments (including Fee-for-Service, Diagnosis-Related Groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2017 or most recent 12 months.	#DIV/0!
Alternative Payment Model Framework - Category 2 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are linked to quality).				
3	Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2017 or most recent 12 months.	#DIV/0!

4	Total dollars paid to providers through f**ee-for-Service plus pay-for-performance** payments (linked to quality) in CY 2017 or most recent 12 months.	$0.00	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2017 or most recent 12 months. * CPR historic metric - trend.	#DIV/0!
5	Total dollars paid in **Category 2** in CY 2017 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are linked to quality)				
6	Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2017 or most recent 12 months.	$0.00	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2017 or most recent 12 months.	#DIV/0!
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Questions	Responses		
What payment models were in effect during specified the period of reporting? Please specify the line of business.	Comm	MA	MCO
For each program identified in the prior question, indicate when the program was launched. Please specify the line of business. Provide the launch date in column B, C, or D.	Comm	MA	MCO
For each program identified in the first question, identify its current stage of implementation (Pilot, Expansion, Fully Implemented)*. Please specify the line of business.	Comm	MA	MCO

If dollars are paid to providers through **integrated finance and delivery programs** in CY 2017, please identify the underlying payment method the health plan uses to pay network providers.	**Comm**	**MA**	**MCO**

*

ss-Checking

Foundational spending to improve care
FFS plus Pay for Performance
Traditional Shared Savings
Utilization-based Shared Savings
FFS-based Shared Risk
Procedure-based Bundled/Episode Payments
Population-based Payments that are NOT condition-specific
Condition-specific Population-based Payments
Condition-Specific Bundled/Episode Payments
Full or Percent of Premium Population-based Payment
Integrated Finance and Delivery Programs
Foundational spending to improve care
FFS plus Pay for Performance
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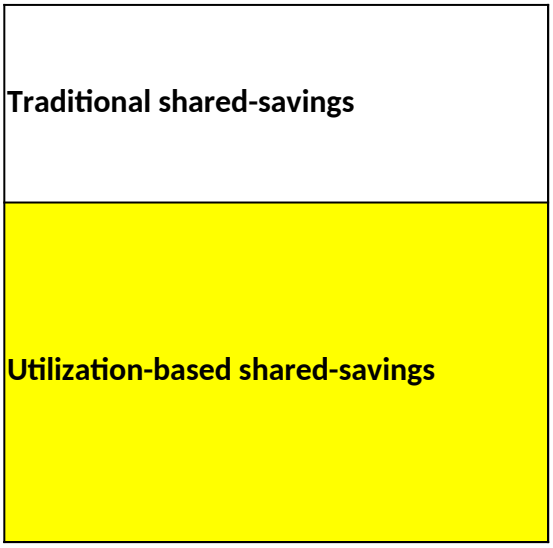
Condition-specific Population-based Payments
Condition-Specific Bundled/Episode Payments
Full or Percent of Premium Population-based Payment

Pilot mode (e.g. only available for a subset of members and/or providers)
Expansion mode (e.g. passed initial pilot stage)
Fully implemented (e.g. generally available)

Terms
Alternative Payment Model (APM)
Appropriate care measures
Category 1
Category 2
Category 3

Category 4
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries
Condition-specific bundled/episode payments
Conditions-specific population-based payment
CY 2017 or most recent 12 months
Diagnosis-related groups (DRGs)
Fee-for-service
Foundational spending
Full or percent of premium population-based payments

Integrated finance and delivery payments
Legacy payments
Linked to quality
Pay-for-performance
Population-based payments that are NOT condition-specific
Procedure-based bundled/episode payment
Provider
Shared-risk
Total dollars


Traditional shared-savings
Utilization-based shared-savings

Definitions

Definitions
Health care payment methods that use financial incentives to promote or leverage greater value - including higher quality care at lower costs - for patients, purchasers, payers and providers. This definition is specific to this exercise. If you are interested in MACRA's definition, please reference MACRA for more details. Refreshed APM Framework White Paper MACRA Website
Appropriate care measures are metrics that are based on evidence based guidelines and comparative effective research. Such measures assess how well providers avoid unnecessarily costly, harmful, and unnecessary procedures. These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g. Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to: unnecessary –readmissions, preventable admissions, unnecessary imaging, appropriate medication use. Measures of appropriate care are required in order for a payment method to qualify as a Category 3 or 4 APM to ensure providers are incentivized to reduce/eliminate care that is wasteful and potentially harmful to patients. Appropriate care measures also ensure providers do not withhold necessary care and are incentivized to provide necessary care.
Fee-for-service with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1.
Fee-for-service linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.
Alternative payment methods (APMs) built on fee-for-service architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers that who meet their quality, and cost or utilization targets are eligible to share in savings, and those who do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. See definition of "appropriate care measures" for a description and examples.

Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.
Health plan enrollees or plan participants.
A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A]**
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**].
Calendar year 2017 or the most current 12-month period for which the health plan can report payment information. This is the 12 month reporting period for which the health plan should report all of its "actual" spend data - a retrospective "look back."
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.
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**]
Includes but is not limited to payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category **2A**]
A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B]**

Payments in which the delivery system is integrated with the finance system and delivers comprehensive care. These integrated arrangements consist of either insurance companies that own provider networks, or delivery systems that offer their own insurance products. The finance and delivery arms work in tandem to ensure that effective delivery investments are being made and that incentives and strategies within the organization are properly aligned.
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**].
Payments that are set or adjusted based on evidence that providers meet quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet a threshold on cost and quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality" in Category 2. In order to qualify as a Category 3 or 4 APM, the link to quality must include “appropriate care measures.” See definition of “appropriate care measures” for a description and examples.
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**].
A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B**].
Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
For the purposes of this workbook, provider includes all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible, and excludes dental and vision.
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.
The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in calendar year (CY) 2017 or most recent 12 months.

A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a pre-established set target for spending, as long as they meet quality targets. Traditional shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.
A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g. Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to: emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets.