Landing Page

2020 Alternative Payment Models Survey

Overview

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

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

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

General

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

Name of organization:

Your full name:

Your work email address:

Your work phone number:

Please select the lines of business in which your organization operated in Calendar Year (CY) 2019. (Select all that apply)

- ☐ Commercial
- ☐ Medicare Advantage
- ☐ Medicaid

What was the total number of members covered by the payer by line of business in CY 2019?

	Commercial	Medicare Advantage	Medicaid
Total number of members			

What was the plan's total health care spend (in- and out-of-network) by line of business in CY 2019?

	Commercial	Medicare Advantage	Medicaid
Total health care spend			

APM Instructions

Goal/purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2019 or most recent 12 months for which data are available.

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

Methods

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

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

For more information, please see the Frequently Asked Questions or email Andréa Caballero at acaballero@catalyze.org

Metrics

Please note that the dollars paid through the various APMs are actual dollars paid to providers in CY 2019 or most recent 12 months. The dollars reported for each payment model serve as numerators to track the percentage of total dollars (the denominator) across the different APM subcategories. Numerators should not be calculated based on members attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

Alternative Payment Model Framework – APM Models in Effect

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

	Commercial	Medicare Advantage	Medicaid
Foundational spending to improve care	☐	☐	☐
Fee-for-service plus pay-for-performance	☐	☐	☐
Traditional shared-savings	☐	☐	☐
Utilization-based shared savings	☐	☐	☐
Fee-for-service-based shared-risk	☐	☐	☐
Procedure-based bundled/episode payments	☐	☐	☐
Condition-specific, population-based payments	☐	☐	☐
Condition-specific, bundled/episode payments	☐	☐	☐
Population-based payments that are NOT condition-specific	☐	☐	☐
Full or percent of premium population-based payments	☐	☐	☐
Integrated finance and delivery programs	☐	☐	☐

Commercial Line of Business

Please list the total dollars paid through each of the payment models that were in effect in your organization's commercial line of business in 2019.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.

Legacy Payments: _____

Foundational spending to improve care: _____

Fee-for-service plus pay-for-performance: _____

Traditional shared savings: _____

Utilization-based shared savings: _____

Fee-for-service-based shared risk: _____

Procedure-based bundled/episode payments: _____

Condition-specific, population-based payments: _____

Condition-specific bundled/episode payments: _____

Population-based payments that are NOT condition-specific: _____

Full or percent of premium population-based payments: _____

Integrated finance and delivery programs: _____

Total: _____

Medicare Advantage Line of Business

Please list the total dollars paid through each of the payment models that were in effect in 2019 in your organization's Medicare Advantage line of business.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.

Legacy Payments: _____

Foundational spending to improve care: _____

Fee-for-service plus pay-for-performance: _____

Traditional shared savings: _____

Utilization-based shared savings: _____

Fee-for-service-based shared risk: _____

Procedure-based bundled/episode payments: _____

Condition-specific, population-based payments: _____

Condition-specific bundled/episode payments: _____

Population-based payments that are NOT condition-specific: _____

Full or percent of premium population-based payments: _____

Integrated finance and delivery programs: _____

Total: _____

Medicaid Line of Business

Please list the total dollars paid through each of the payment models that were in effect in 2019 in your organization's Medicaid line of business.

Note: To the extent payment to a provider includes multiple APMs, the payers should put the dollars in the dominant APM, meaning the most advanced method. Therefore, there may be some payment models that were in effect but do not have dollars associated as they were not the dominant APM in the arrangement with the provider.

Legacy Payments: _____

Foundational spending to improve care: _____

Fee-for-service plus pay-for-performance: _____

Traditional shared savings: _____

Utilization-based shared savings: _____

Fee-for-service-based shared risk: _____

Procedure-based bundled/episode payments: _____

Condition-specific, population-based payments: _____

Condition-specific bundled/episode payments: _____

Population-based payments that are NOT condition-specific: _____

Full or percent of premium population-based payments: _____

Integrated finance and delivery programs: _____

Total: _____

Review Process

Please take a moment to review your data entry.

The sum of the dollars listed for each payment model (the numerators) should account for exactly 100% of the total dollars paid to providers in 2019 (the denominator). If the sum of the numerators does not equal the denominator, the LAN Measurement Team will email you to identify where dollars are missing or are double counted.

Commercial Line of Business

Total dollars reported for Commercial (denominator): [The online survey will display what was previously provided by respondent]

Total dollars reported across the APMs in effect in the commercial market (sum of the numerators): [The online survey will display the sum of the numerators provided by the respondent]

Medicare Advantage Line of Business

Total dollars reported for Medicare Advantage: [The online survey will display what was previously provided by respondent]

Total dollars reported across the APMs in effect in the Medicare Advantage market (sum of the numerators): [The online survey will display the sum of the numerators provided by the respondent]

Medicaid Line of Business

Total dollars reported for Medicaid (denominator): [The online survey will display what was previously provided by respondent]

Total dollars reported across the APMs in effect in the Medicaid market (sum of the numerators): [The online survey will display the sum of the numerators provided by the respondent]

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

☐ Yes

☐ No

[Display if "No" is selected]
Common issues for why the sum of the numerators is not equal to the denominator:

- If the sum of the numerators is **greater than** the denominator:
  - Double counting of APM dollars: When a provider arrangement includes more than one type of payment method, all dollars flowing through that arrangement should be categorized today in the most advanced or "dominant" APM.
- If the sum of the numerators is **less than** the denominator:
  - Not accounting for the underlying fee-for-service payments: Dollars categorized as an APM Categories 2 and 3 rely on a fee-for-service architecture. Payments classified as APMs should include the underlying fee-for-service payments in addition to any incentives, bonuses, or savings shared with the provider.

If you are able to resolve the issue, please use the back button to edit responses. If you have questions on how to categorize dollars, please contact Andréa Caballero at acaballero@catalyze.org.

Understanding Nominal Risk in 3B FFS-Based Shared Risk Contracts

Background

In 2018, the LAN began aggregating spend in categories 3B and above because the payment models included in these categories require providers to take two-sided risk – meaning that providers hold financial liability if they fail to achieve their contracted cost and quality goals. Two-sided risk APMs hold promise for driving this fundamental change, because they promote incentives and flexibility to innovate and improve care delivery.

At the 2019 LAN Summit, the LAN adopted new goals to accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk APMs.

The 2020 LAN Measurement Effort will serve as an opportunity for the LAN to learn about measuring two-sided risk arrangements, specifically shared risk payments (3B), by using a "nominal risk" threshold. The term "nominal risk" is a reference to the threshold established by

CMS when CMS designed the Quality Payment Program (QPP) to determine qualifying characteristics of Advanced Alternative Payment Models (AAPMs). QPP and the LAN both define nominal risk as at least 3 percent of expected expenditures (benchmark-based standard) or 8 percent of average expected revenue (revenue-based standard). A notable difference between QPP and the LAN is that the LAN does not factor in the mechanism for recouping losses when determining nominal risk.

The LAN encourages health plans and other payers to help increase understanding about FFS-based shared risk arrangements by participating in this section of the survey related to nominal risk.

For more information on the LAN goal's, please see the Goals FAQs. For more information on the 2020 LAN Measurement Effort and nominal risk, please see FAQs.

Instructions

Purpose = Track total dollars paid through FFS-based shared risk contracts that meet the threshold for the LAN's nominal risk specifications. The goal is NOT to gather competitively sensitive or contractual plan information.

Methods

Plans should report the dollars that met the nominal risk threshold, and those that did not. The Worksheet tab within the LAN Nominal Risk Calculation Excel file is designed to help you discern which contracts met the LAN's nominal risk threshold, and will aggregate dollars accordingly (see graphic below). Alternatively, if you know that 100% of your shared risk contracts met the LAN's nominal risk threshold, you can skip the worksheet.

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

Please refer to the plan-level data as it appears in this section of the LAN Nominal Risk Calculation Worksheet

	DID MEET LAN Nominal Risk Threshold		DID NOT MEET LAN Nominal Risk Threshold		Total FFS-Based Shared Risk	
Line of Business	Dollars	% Total Spend	Dollars	% Total Spend	Dollars	% Total Spend
Commercial	$ -		$ -		$ -	
Medicare	$ -		$ -		$ -	
Medicaid	$ -		$ -		$ -	
Total	$ -		$ -		$ -	

Please select one of the following choices for your organization:

- ☐ My organization reports that all dollars across all lines of business in which we had 3B-FFS-Based Shared Risk arrangements met the LAN nominal risk threshold.

[Display for respondents who are reporting dollars for more than one line of business].

- ☐ My organization reports that all dollars flowing through at least one line of business in which my organization had 3B-FFS-Based Shared Risk arrangements met the LAN nominal risk threshold.

- ☐ My organization would like to report the FFS-Based Shared Risk dollars that DID and DID NOT MEET the LAN's nominal risk threshold across all line of business in which my organization had shared risk arrangements.

- ☐ My organization would like to skip the nominal risk questions but provide feedback on nominal risk measurement.

[Display to those who selected the second answer choice above]

Please select the lines of business for which your organization would like to report the FFS-based shared risk dollars that DID and DID NOT meet the LAN's nominal risk threshold.

- ☐ Commercial
- ☐ Medicare Advantage
- ☐ Medicaid

[Display to those who select to report nominal risk dollars]

What is the plan's total dollars flowing through shared risk contracts that DID MEET the LAN nominal risk threshold?

	Commercial	Medicare Advantage	Medicaid
Total dollars in shared risk contracts that DID MEET LAN nominal risk threshold			

What is the plan's total dollars flowing through shared risk contracts that DID NOT MEET the LAN nominal risk threshold?

	Commercial	Medicare Advantage	Medicaid
Total dollars in shared risk contracts that DID NOT MEET LAN nominal risk threshold			

Feedback on Metrics for Understanding Nominal Risk in 3B FFS-Based Shared Risk Contracts

How would you describe the experience of gathering the necessary data to prepare your organization's data entry? (Select one)

- ☐ Extremely easy
- ☐ Somewhat easy
- ☐ Neither easy nor difficult
- ☐ Somewhat difficult
- ☐ Extremely difficult

[Display for respondents who selected to skip the nominal risk questions]
My organization was unable to gather the necessary data

Please provide any feedback you have on the feasibility or reporting burden associated with the LAN's nominal risk metric. (E.g. Ability to gather contractual elements necessary to respond to the survey; ease of use of LAN Nominal Risk Calculation worksheet; etc.)

How would you describe the usefulness of the LAN's nominal risk metric for either internal or external reporting? (Select one)

- ☐ Extremely useful
- ☐ Somewhat useful
- ☐ Moderately useful
- ☐ Slightly useful
- ☐ Not at all useful

Please provide any feedback you have on the usefulness of the LAN's nominal risk metric. Specifically, if you answered "moderately useful, slightly useful, or not at all useful, it would help the LAN learn how nominal risk measurement could be more useful to your organization. (The LAN will not attribute comments to you or your plan.)

APM Trends

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

- [ ] APM activity will increase
- [ ] APM activity will stay the same
- [ ] APM activity will decrease
- [ ] Not sure

[Display this question If "APM activity will increase" is selected] **Which APM subcategory do you think will increase the most in activity over the next 24 months?**

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

[Display this question If "APM activity will decrease" is selected] **Which APM subcategory do you think will decrease the most in activity over the next 24 months?**

- [ ] Traditional shared-savings, Utilization-based shared-savings (3A)
- [ ] Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)
- [ ] Condition-specific, population-based payments, Condition-specific bundled/episode payments (4A)

- [ ] Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)
- [ ] Integrated finance and delivery programs (4C)
- [ ] Not sure

APM Barriers

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

- [ ] Provider interest / readiness
- [ ] Health system interest / readiness
- [ ] Purchaser interest / readiness
- [ ] Government influence
- [ ] Provider ability to operationalize
- [ ] Health plan ability to operationalize
- [ ] Interoperability
- [ ] Provider willingness to take on financial risk
- [ ] Market factors
- [ ] Other (please list)

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

- [ ] Provider interest / readiness
- [ ] Health system interest / readiness
- [ ] Purchaser interest / readiness
- [ ] Government influence
- [ ] Provider ability to operationalize

- [ ] Health plan ability to operationalize
- [ ] Interoperability
- [ ] Provider willingness to take on financial risk
- [ ] Market factors
- [ ] Other (please list)

APM Outcomes

From health plan's perspective, please indicate to what extent you agree or disagree that APM adoption will result in each of the following outcomes

	Strongly disagree	Disagree	Agree	Strongly agree	Not sure
Better quality care	☐	☐	☐	☐	☐
More affordable care	☐	☐	☐	☐	☐
Improved care coordination	☐	☐	☐	☐	☐
More consolidation among health care providers	☐	☐	☐	☐	☐
Higher unit prices for discrete services	☐	☐	☐	☐	☐

Assumptions

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.

	Commercial	Medicare Advantage	Medicaid
Hours to complete			

End

Congratulations! You have finished the survey. If you are ready to submit your responses and exit the survey, please click the "Submit" button. If you wish to review your responses, you may use the back button below or the table of content menu in top left corner.

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Definitions

Term	Definition
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. Refreshed APM Framework White Paper MACRA Website
Appropriate care measures	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.
Category 1	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.

Term	Definition
Category 2	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.
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 (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.
Category 4	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.

Term	Definition
Commercial Market	For the purposes of this survey, the commercial market segment includes individual, small group, large group, fully insured, self-funded and exchange business. To the extent a health plan provides benefits for the Federal Employee Health Benefit (FEHB) program, state active employee programs, and/or an exchange, this business should be considered commercial and included in the survey. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019 or the most recent 12-month period for which data is available. Spending for dental and vision services are excluded. See "General Information" tab in the Excel workbook for more information.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants. See Frequently Asked Questions for more information.
Condition-specific bundled/episode payments	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]**
Conditions-specific population-based payment	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. See Frequently Asked Questions for more information. [APM Framework Category 4A]
CY 2019 or most recent 12 months	Calendar year 2019 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."

Term	Definition
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**]
Fee-For Service Based 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. [APM Framework **3B**]
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 **2A**]
Full or percent of premium population-based payments	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]**

Term	Definition
Integrated finance and delivery system payments	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, or payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships. See Frequently Asked Questions for more information. [APM Framework Category **4C**]
LAN Nominal Risk Threshold	For the purpose of the LAN, a contract must meet 3 criteria to qualify as having Nominal Risk: A risk minimum <=4%; Provider Risk Share of >=30%, and Net Risk of 3% for a TCOC contract or 8% for a % Revenue contract
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 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.
Medicaid Market	For the purposes of this survey, the Medicaid market segment includes both business with a state to provide health benefits to Medicaid eligible individuals and state-run programs themselves. Data submitted for this survey should exclude the following: health care spending for dual-eligible beneficiaries, health care spending for long-term services and supports (LTSS), spending for dental and vision services. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019 or the most recent 12-month period for which data is available. See “General Information” tab in the Excel workbook for more information.

Term	Definition
Medicare Advantage Market	For the purposes of this survey, the Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it should include this information in its response. Responses to the survey will reflect dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019 or the most recent 12-month period for which data is available. Dental and vision services are excluded. See "General Information" tab in the Excel workbook for more information.
Net Risk aka *Total Risk*	Net risk combines the risk maximum with risk share to assess the provider's total liability. Net Risk is calculated by multiplying Risk Cap*Net Risk. For example, a contract with a risk cap of 10% and a shared risk of 60% has a net risk score of 6%.
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**].

Term	Definition
Percent Revenue Contract	A percent revenue contract holds provider accountable for professional and facility costs furnished by the *accountable provider organization* only.
Population-based payments that are NOT condition-specific	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 cover primary, acute and post-acute care that is not specific to any particular condition. [APM Framework Category **4B**]
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 **3B**].
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, and excludes dental and vision.
Recoupment	The mechanism by which the health plan recovers the provider's share of incurred losses (e.g. withholding payment, reducing payment rates, requiring direct payments back to the payer or carrying the loss forward into the next payment period)
Reinsurance	In this context, a reimbursement system that protects providers from losses. A health plan can offer reinsurance to providers in two-sided risk contracts, or providers may purchase reinsurance from a third party. See also "Stop Loss Insurance"

Term	Definition
Risk Minimum aka Minimum Loss Rate, or Risk Corridor	The Risk Minimum establishes a minimum level of loss (or gain) that must be realized before risk sharing (or shared savings) is applied. The Risk Minimum is a mechanism designed to ensure the statistical likelihood that calculated losses are actual losses, and not due to random variation. For example, if a provider group has a PMPM cost target of $200 and a risk minimum of 3%, they would not incur any penalties unless their PMPM cost exceeded $206.
Risk Maximum *aka Risk Cap*	The Risk Maximum is the maximum amount a provider can go over their cost target before losses are capped. For example, if a provider has a PMPM target of $200 and a risk cap of 10%, the penalty they are liable for is capped at $220 PMPM.
Provider Risk Share (aka Marginal Risk)	The Provider Risk Share indicates the proportional liability the provider is accountable for, viz. the health plan or payer. For example, if a provider exceeds their cost target by $50, and is a 60/40 risk share agreement, they are only liable for $30 of loss.
Stop Loss Insurance	Stop loss insurance (also known as excess insurance) is a product that offers providers protection against catastrophic or unpredictable losses. See also “Reinsurance.”
Total Cost of Care (TCOC) Contract (aka Benchmark-based)	A total cost of care contract holds providers accountable for all costs incurred by their attributed patient population, including professional, pharmacy, hospital, ancillary care and administrative payments. The contracted provider group is responsible for costs regardless of who furnished the patients' care.
Total Dollars (Contract Level)	The total dollars flowing through a particular contract - i.e. total costs for attributed members in TCOC contracts, total provider revenue for providers in % revenue contracts, or total costs pertaining to an episode of care
Total dollars (Plan Level)	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in calendar year (CY) 2019 or most recent 12 months.

Term	Definition
Traditional shared savings	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.
Utilization-based shared savings	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.