APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS

2020-2021 Methodology and Results Report

HCPLAN

Health Care Payment Learning & Action Network

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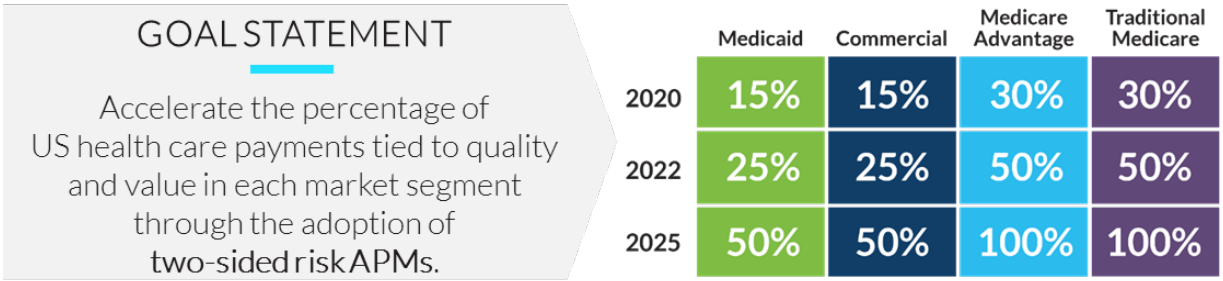
Overview

Alternative payment models (APMs) have the potential to realign payment incentives and care delivery to improve healthcare quality while reducing costs. The Health Care Payment Learning & Action Network (LAN), created to accelerate APM adoption and drive alignment in payment reform approaches across the public and private sectors, adopted and applied goals to the LAN's ongoing initiative. Five years ago, the LAN embarked on its first national APM Measurement Effort to assess the adoption of APMs in the commercial, Medicare Advantage, and Medicaid market segments across the country, with the intention to measure progress toward the goals and to examine how APM adoption is changing over time. The LAN's APM Measurement Effort described in this report marks the sixth year of this initiative.

In October 2019, the LAN established and announced new goals aimed at accelerating adoption of two-sided risk APMs. The variation in the percentages by line of business in the table below reflects that different markets and lines of business are progressing at different rates.

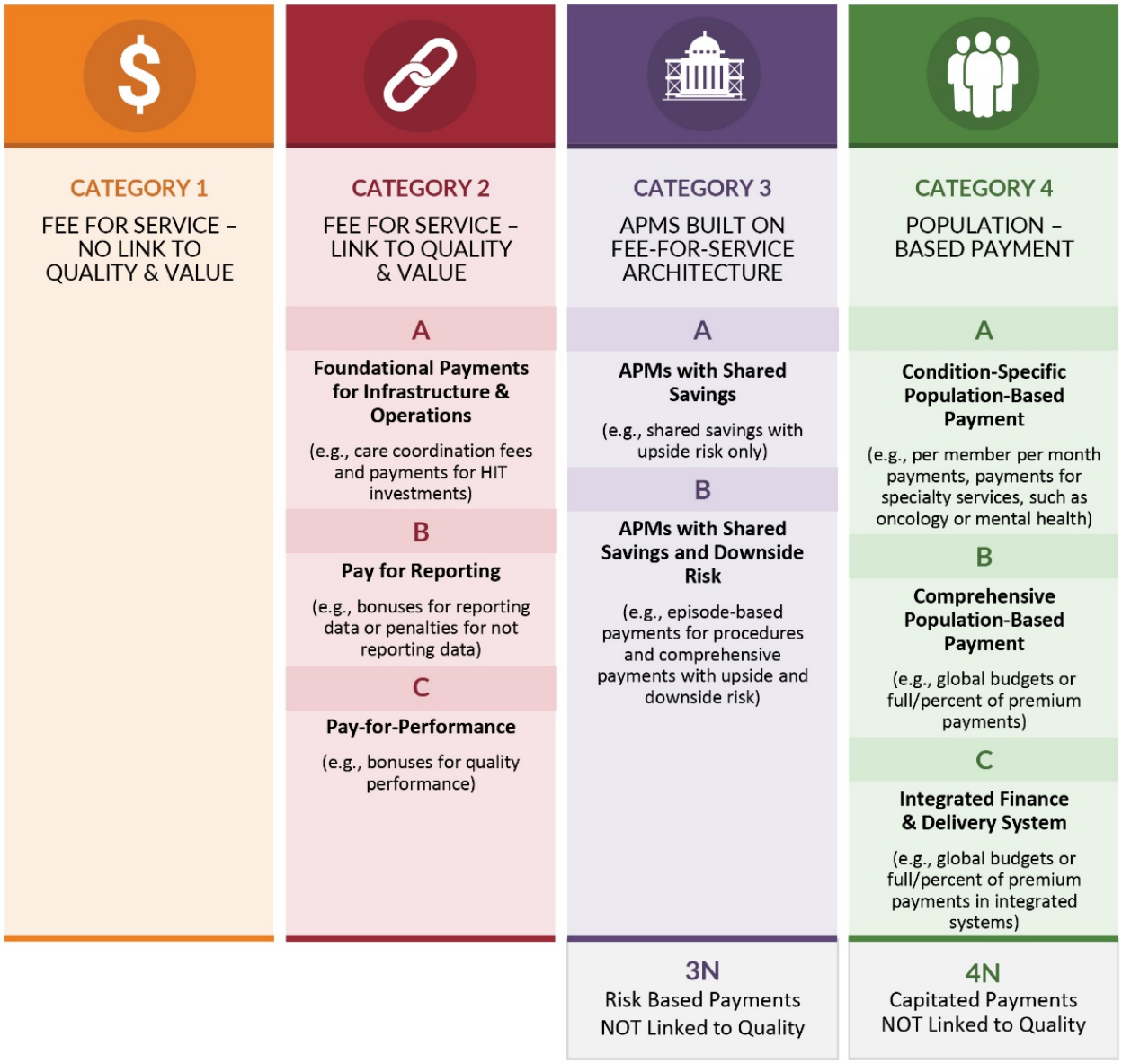


	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

When the LAN established new goals, it also formed a new structure with two Executive Forums, the CEO Forum and the Care Transformation Forum. The Forums drive the leadership and vision of the LAN.

The LAN invited health plans across market segments, as well as fee-for-service (FFS) Medicaid states, to quantify the amount of in- and out-of-network spending that flows through APMs, including key areas of pharmacy and behavioral health spending, if such data was available. Participating plans and states categorized payments according to the LAN's APM Framework (which was refreshed in 2017), using the LAN survey tool, definitions, and methodology (Figure 1).

Figure 1: LAN APM Framework



Two Years of APM Measurement

Recognizing the impact of the COVID-19 public health emergency (PHE) on the healthcare industry, the LAN adjusted its regular Measurement Effort cycle, giving health plans and participating states the opportunity to respond to the survey on a timeline that made sense to the participants' business operations. The LAN reported both 2019 and 2020 APM data concurrently.

The LAN launched the 2020 Measurement Effort to collect 2019 APM data on June 26, 2020 and extended the data collection window to six months (versus the regular two-month collection window). If participants were still unable to submit data by December 31, 2020, the LAN granted further flexibility to allow participants to submit both 2019 and 2020 data during the 2021 Measurement Effort, which was conducted on a regular cycle.

All six LAN APM Measurement Efforts requested health plans and states to provide retrospective data of actual dollars paid to providers during the previous calendar year (CY) or the most recent 12-month period for which the data was available.

A total of 69 health plans, six FFS Medicaid states, and Traditional Medicare participated in the 2020 Measurement Effort, representing approximately 216,368,921 of the nation's covered lives and 72.5% of the national market. The percentage of the national market is based on a denominator of approximately 298,438,000 lives covered by any health insurance plan.[1] More information on 2019 payment results can be found here: https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/.

The results demonstrated the following for payments made during CY 2019:

- 39.3% of healthcare dollars in Category 1
- 22.5% of healthcare dollars in Category 2
- 31.8% of healthcare dollars in Category 3
- 6.4% of healthcare dollars in Category 4

A total of 73 health plans, five FFS Medicaid states, and Traditional Medicare participated in the 2021 Measurement Effort, representing approximately 238,752,033 of the nation's covered lives and 80.2% of the national market. The percentage of the national market is based on a denominator of approximately 297,680,000 lives covered by any health insurance plan.[2] More information on 2020 payment results can be found here: https://hcp-lan.org/apm-measurement-effort/2020-2021-apm/.

The results demonstrated the following for payments made during CY 2020:

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[1] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2019; Current Population Reports." Issued September 2020. Available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf. Accessed November 3, 2021.

[2] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2020; Current Population Reports." Issued September 2021. Available at https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf. Accessed November 3, 2021.

- 39.3% of healthcare dollars in Category 1
- 19.8% of healthcare dollars in Category 2
- 34.2% of healthcare dollars in Category 3
- 6.7% of healthcare dollars in Category 4

Data Sources

The LAN continued to collaborate with AHIP (formerly known as America's Health Insurance Plans), the Blue Cross Blue Shield Association (BCBSA), and the Centers for Medicare & Medicaid Services (CMS), requesting data from health plans, states, and the Traditional Medicare program. Consistent with the 2018 and 2019 efforts, the LAN, AHIP, and BCBSA included informational questions about the future of APM adoption and collected payment data by line of business (i.e., commercial, Medicaid, Medicare Advantage, and Traditional Medicare), and at the payment level within the various subcategories (e.g., pay-for-performance, shared risk).[3] This granular data provides actionable insights into the state of APMs in the different market segments, and the qualitative insights collected through the informational questions help enhance the quantitative results by identifying the potential future trajectory of APMs.

To better understand how organizations were responding to the impact of COVID-19, the LAN made two updates to the 2021 APM Measurement Effort survey: adding informational questions and modifying the survey tool. The LAN included three additional informational questions related to population-based payments and health equity. These changes were made in consultation with AHIP, BCBSA, CMS, and individual payers who are familiar with the Measurement Effort. All entities agreed to include the new informational questions, and all changes were communicated to participating payers during training webinars and through the Frequently Asked Questions resource for participating payers. The LAN and AHIP also modified their Qualtrics survey tool to streamline questions and included features whereby potential errors in the data are identified before submission.

Health plans had multiple paths to contribute to the LAN APM Measurement Effort. In addition to the LAN's data collection efforts (see the LAN Survey section below), AHIP and BCBSA fielded surveys to their member health plans in both 2020 and 2021. All three avenues of data collection requested that health plans report the total dollars paid to providers by line of business and at the payment method level. AHIP and BCBSA identified health plans that are members of both organizations and coordinated to ensure there were no duplicate responses in the respective data sets.

The 2020 and 2021 LAN APM Measurement Efforts combined data from the AHIP survey, the BCBSA survey, the LAN survey, and Traditional Medicare data. Health plans, states, and Traditional Medicare reported the total dollars paid to providers through the payment methods within the subcategories according to the refreshed LAN APM Framework. With this data, the LAN calculated aggregate results

[3] In the 2020 measurement survey, the LAN and partner organizations piloted a voluntary metric related to the measurement of nominal risk for entities with shared risk arrangements (3B). The metric is viable, but it did not yield sufficient responses, so the LAN and partner organizations agreed to remove this metric from the 2021 survey.

for 2019 and 2020 separately by line of business and at the payment method level by category and subcategory.

The LAN Survey

The 2020 LAN data collection period to capture CY 2019 data started on June 26, 2020 and extended through December 31, 2020.[4] The 2021 LAN data collection period to capture CY 2020 data started on May 24, 2021 and ended on July 30, 2021.

The LAN used metrics to determine the extent of APM adoption, asking health plans and states to report dollars paid in CY 2019 or in the most recent 12 months for which it had data and in CY 2020 or the most recent 12 months for which it had data. Health plan and state participation, as well as individual data, was kept confidential. Some health plans participating through the LAN elected to execute a data-sharing agreement with The MITRE Corporation as the operator of the Health FFRDC. In order to maintain the impartiality and participant confidentiality of the Department of Health and Human Services (HHS), the Health FFRDC, and not HHS, received, analyzed, and aggregated all individual plan and state data.

Because most payment innovations typically incorporate multiple payment methods (e.g., FFS plus a care coordination fee and shared savings), plans and states were asked to report dollars paid according to the most dominant or advanced payment method they used (e.g., shared savings or condition-specific population-based payments). The Health FFRDC reviewed health plan responses to identify outlier or inconsistent data and provided follow-up questions to plans and states to support data integrity. Health plans and states either clarified or modified their responses as appropriate.

The method for calculating the metrics required health plans and states to retrospectively examine the actual payments they made to providers in CY 2019 and in CY 2020 (or in the most recent 12 months for which they had data) through the different APMs and categorize them accordingly. For APMs in Categories 3 and 4, some of which hold providers accountable for their patients' total cost of care, health plans could report dollars paid based on members attributed to the method.[5]

The data collected through the LAN survey is described in Tables 1, 2 and 3. AHIP and BCBSA collected data identical to that collected through the LAN survey (see AHIP Survey and Blue Cross Blue Shield Association Survey and sections below).

[4] As part of the LAN's "flexible measurement effort" during the PHE, CY 2019 data was accepted until the end of the 2021 Measurement Effort collection period.

[5] For more information and guidance on categorizing payments, including capitation without quality, see the National APM Data Collection Frequently Asked Questions for 2021.

Table 1: 2020 and 2021 Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2019/2020 or most recent 12 months.	*Denominator to inform the metrics below.*

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 1 (METRICS ARE NOT LINKED TO QUALITY)	
Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2019/2020 or most recent 12 months.	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 2019/2020 or most recent 12 months.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 2A)	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-reporting** payments (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 2B)	Dollars in pay-for-reporting programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2019/2020 or most recent 12 months.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **fee-for-service plus pay-for-performance** payments (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 2C)	Dollars in pay-for-performance programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2019/2020 or most recent 12 months.
Total dollars paid in **Category 2** in CY 2019/2020 or most recent 12 months.	Payment Reform – APMs built on fee-for-service linked to quality: Percent of total dollars paid in Category 2.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 3 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2019/2020 or most recent 12 months. (Subcategory 3A)	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2019/2020 or most recent 12 months. (Subcategory 3A)	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2019/2020 or most recent 12 months. (Subcategory 3B)	Dollars in fee-for-service-based shared-risk programs: Percent of total dollars paid through fee-for-service-based shared-risk (linked to quality) payments in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2019/2020 or most recent 12 months. (Subcategory 3B)	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2019/2020 or most recent 12 months.
Total dollars paid in **Category 3** in CY 2019/2020 or most recent 12 months.	Payment Reform – APMs built on fee-for-service architecture: Percent of total dollars paid in Category 3.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 4 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 4A)	Condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific, population-based payments (linked to quality) in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 4A)	Dollars in condition-specific, bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode payments (linked to quality) in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 4B)	Population-based payments that are not condition-specific (linked to quality): Percent of total dollars paid through population-based payments that are not condition-specific (linked to quality) in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 4B)	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 (linked to quality) in CY 2019/2020 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery system programs** (linked to quality) in CY 2019/2020 or most recent 12 months. (Subcategory 4C)	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs (linked to quality) in CY 2019/2020 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2019/2020 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

Table 2: Informational Questions

QUESTIONS	RESPONSE OPTIONS
From 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
[To those who answered "APM activity will increase"] 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) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure
[To those who answered "APM activity will decrease"] 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) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure
From health plan's perspective, what are the top barriers to APM adoption? (Select up to 3)	• Provider interest/readiness • Health plan 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)

QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, what are the top facilitators to APM adoption? (Select up to 3)	• Provider interest/readiness • Health plan 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, please indicate to what extent you agree or disagree that APM adoption will result in each of the following outcomes:	• Better quality care (strongly disagree, disagree, agree, strongly agree, not sure) • More affordable care (strongly disagree, disagree, agree, strongly agree, not sure) • Improved care coordination (strongly disagree, disagree, agree, strongly agree, not sure) • More consolidation among healthcare providers (strongly disagree, disagree, agree, strongly agree, not sure) • Higher unit prices for discrete services (strongly disagree, disagree, agree, strongly agree, not sure) • Other (please list) (strongly disagree, disagree, agree, strongly agree, not sure)

In response to the PHE, the LAN launched the Healthcare Resiliency Collaborative to articulate, and commit to, the most important action steps for healthcare resiliency in both the short and long term. The PHE also exposed significant health disparities and inequities in our healthcare system. In response to these issues, and to gain insights from health plans on their actions relative to these issues, the LAN added three questions to the informational section of the survey.

Table 3: Informational Questions Added in the 2021 Measurement Survey

QUESTIONS	RESPONSE OPTIONS
Does your Plan have a strategy to contract with providers using population-based APMs (i.e., HCP LAN Category 4) over the next year? If yes, please **check all responses** that apply.	• The strategy is/will mostly target small, independent primary care clinicians/practices. • The strategy is/will mostly target independent larger physician group practices. • The strategy is/will target a mix of provider types. • No, my Plan does not have a strategy to contract with providers using population-based APMs. • Other (text)
Is your Plan leveraging value-based provider arrangements to incent the reduction of health disparities? If yes, please **check all responses** that apply.	• Collect standardized sociodemographic data • Improve the quality and completeness of sociodemographic data • Measure health disparities by stratifying along sociodemographic factors • Improve performance on measures stratified by sociodemographic data • Improve patient consumer experience for targeted populations

QUESTIONS	RESPONSE OPTIONS
If incentives are included in your value-based provider arrangements to improve health disparities, what specific Social Determinants of Health (SDoH) or delivery strategies are targeted for improvement or enhancement? Check all that apply.	• Screening for socioeconomic barriers to health • Multidisciplinary team models (e.g., social worker, community health worker, medical staff, doulas, etc.) • Referrals to community-based organizations to address socioeconomic barriers • Data that tracks whether services were received (e.g., closed loop referrals) • Care coordination for services that address socioeconomic barriers • Food insecurity (e.g., offering resources for access to nutritious food) • Safe transportation (e.g., incentives or partnerships in ride sharing programs) • Housing insecurity (e.g., provider sponsored housing after a hospital discharge) • Economic insecurity (e.g., connections to job placement or training services) • Social isolation and loneliness (e.g., peer connection programs, group meetings, etc.) • Other basic needs (e.g., providing clothing, diapers, or gift cards; helping with utilities or childcare; providing digital devices such as phones to access telehealth and thrive in new digital world, etc.) • Other

The AHIP Survey

The 2020 and 2021 surveys were fielded by AHIP and administered through Qualtrics software (Qualtrics, Provo, UT). Questions focused on the dollars associated with APMs, as defined using the refreshed LAN APM Framework. AHIP recruited its member health plans through email and phone outreach. Using a key informant approach, AHIP initially emailed survey invitations to respondents from the prior year. If the designee was no longer with the organization or unresponsive, follow-up was undertaken with chief medical officers, provider contracting leads, and payment innovation staff from their member plans, who then shared the survey with their teams, as appropriate. AHIP member plans responded directly to AHIP, and only aggregate data was shared with the LAN.

After responses were received, AHIP contacted health plans with follow-up questions for clarifications as appropriate.

The Blue Cross Blue Shield Association Survey

To collect the data points in Tables 1, 2 and 3, BCBSA included questions in an annual survey of member Plans addressing the delivery of value-based healthcare. BCBSA collaborated with the LAN and AHIP to ensure alignment of survey questions to facilitate data aggregation.

BCBSA reported the data elements in Table 1, Table 2, and Table 3, and those listed below, in aggregate to the LAN for the purposes of measuring multiple payers' adoption of APMs nationally:

- Total number of participating Plans
- Total number of covered lives by participating Plans

The data elements listed above reflect 2019 and 2020 data and were submitted to, validated by, and aggregated by BCBSA. Data was collected for healthcare spending paid to all providers for dates of service in CY 2019/2020 (January 1 to December 31) or the most recent 12-month period, while the covered lives data point was requested as a "point in time" for December 31, 2019, and December 31, 2020.

Traditional Medicare

CMS reported Traditional Medicare spending in CY 2019/2020 to the LAN. CMS also collaborated with AHIP, BCBSA, and the LAN to align methodologies and facilitate data aggregation for reporting national progress. The CY 2019/2020 Medicare Parts A and B data elements that were reported to the LAN are the data elements in Table 1, which include the total dollars paid to providers participating in Traditional Medicare APMs in CY 2019/2020 by subcategory and category.

The Traditional Medicare results are considered interim because they are based on only three quarters of CY 2019/2020 actual claims data. Due to claims run-out and data lag issues, each quarter of actual claims data becomes available seven to eight months after the end of the quarter.

The alternative payment models CMS used to calculate the percent of payments made through Categories 3 and 4 of the APM Framework in CY 2019/2020 include shared savings, shared risk, bundled payments, and population-based payment models. The most recent 2021 CMS Office of the Actuary (OACT) annual Part A and B expenditure data is used to calculate the denominator and is obtained directly from OACT.

Merging the Data

The LAN merged the data elements from the AHIP and BCBSA surveys, as well as those reported by Traditional Medicare, with those submitted directly to the LAN.

Results: Payments Made in CY 2019 and CY 2020

Results are presented by line of business (Aggregate, Commercial, Medicaid, Medicare Advantage, and Traditional Medicare) in the sections below.

Aggregate – All lines of business of respondents reporting at the subcategory level

The combined LAN, BCBSA, AHIP, and Traditional Medicare data, representing 72.5% of the national market in 2019 and 80.2% in 2020,[6] shows the following subcategory level payments made to providers in CY 2019 and CY 2020 in all lines of business:

CATEGORY	CY 2019	CY 2020
CATEGORY 1	TOTAL 39.3%	TOTAL 39.3%
CATEGORY 2	TOTAL 22.5%	TOTAL 19.8%
• Foundational payments to improve care (2A)	SUBTOTAL 0.1%	SUBTOTAL 0.2%
• Fee-for-service plus pay-for-reporting payments (2B)	SUBTOTAL 0.0%	SUBTOTAL 0.0%
• Fee-for-service plus pay-for-performance payments (2C)	SUBTOTAL 22.4%	SUBTOTAL 19.6%
CATEGORY 3	TOTAL 31.8%	TOTAL 34.2%
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 21.7%	SUBTOTAL 23.0%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	SUBTOTAL 10.1%	SUBTOTAL 11.2%
CATEGORY 4	TOTAL 6.4%	TOTAL 6.7%
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 2.4%	SUBTOTAL 2.0%

[6] 69 health plans, six states, Traditional Medicare in 2019; 73 health plans, five states, Traditional Medicare in 2020.

CATEGORY	CY 2019	CY 2020
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	SUBTOTAL 3.6%	SUBTOTAL 4.1%
• Integrated finance and delivery system programs (4C)	SUBTOTAL 0.4%	SUBTOTAL 0.6%
CATEGORIES 3 & 4, COMBINED	TOTAL 38.2%	TOTAL 40.9%
CATEGORIES 3B & 4, COMBINED	TOTAL 16.5%	TOTAL 17.9%

INFORMATIONAL QUESTIONS				
PAYERS WHO THINK APM ACTIVITY:	*WILL INCREASE*	*WILL STAY THE SAME*	*WILL DECREASE*	*PAYERS WHO ARE NOT SURE/DECLINED TO RESPOND*
2019	87.0%	7.0%	0.0%	6.0%
2020	87.0%	12.0%	0.0%	1.0%

PAYERS STATING THAT THE APM SUBCATEGORY THAT WILL INCREASE THE MOST WILL BE:		
	2019	**2020**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments **(3B)**	51.0%	47.0%
• Traditional shared-savings, Utilization-based shared-savings **(3A)**	26.0%	21.0%

TOP THREE BARRIERS TO APM ADOPTION AS IDENTIFIED BY PAYERS
SAME RESPONSES AND ORDER IN 2019 AND 2020

1. Provider willingness to take on financial risk
2. Provider ability to operationalize
3. Provider interest/readiness

TOP THREE FACILITATORS TO APM ADOPTION AS IDENTIFIED BY PAYERS
SAME RESPONSES AND ORDER IN 2019 AND 2020

1. Health plan interest/readiness
2. Provider interest/readiness
3. Government influence

INFORMATIONAL QUESTIONS			
PAYERS WHO AGREE OR STRONGLY AGREE WITH AND PAYERS WHO DISAGREE OR STRONGLY DISAGREE WITH THE FOLLOWING:[7]		*AGREE/ STRONGLY AGREE*	*DISAGREE/ STRONGLY DISAGREE*
• APM adoption will result in better quality of care	**2019**	91.0%	5.0%
	2020	92.0%	5.0%
• APM adoption will result in more affordable care	**2019**	86.0%	2.0%
	2020	85.0%	3.0%
• APM adoption will result in improved care coordination	**2019**	91.0%	5.0%
	2020	93.0%	4.0%
• APM adoption will result in more consolidation among healthcare providers	**2019**	44.0%	18.0%
	2020	44.0%	23.0%
• APM adoption will result in higher unit prices for discrete services	**2019**	7.0%	59.0%
	2020	8.0%	64.0%
• Other (please list)		0%	0%

ADDITIONAL INFORMATIONAL QUESTIONS IN 2021 MEASUREMENT SURVEY ONLY		
Does your Plan have a strategy to contract with providers using population-based APMs (i.e., HCP LAN Category 4) over the	11.0%	The strategy is/will mostly target small, independent primary care clinicians/practices.
	15.0%	The strategy is/will mostly target independent larger physician group practices.
	61.0%	The strategy is/will target a mix of provider types.

[7] The percentages for each outcome do not add up to 100% because the "not sure" responses were removed from the data reported here.

ADDITIONAL INFORMATIONAL QUESTIONS IN 2021 MEASUREMENT SURVEY ONLY		
next year? If yes, please check all responses that apply.[8]	22.0%	No, my Plan does not have a strategy to contract with providers using population-based APMs.
	5.0%	Other (text)
Is your Plan leveraging value-based provider arrangements to incent the reduction of health disparities? If yes, please check all responses that apply.	58.0%	Collect standardized sociodemographic data
	47.0%	Improve the quality and completeness of sociodemographic data
	41.0%	Measure health disparities by stratifying along sociodemographic factors
	19.0%	Improve performance on measures stratified by sociodemographic data
	30.0%	Improve patient consumer experience for targeted populations
	23.0%	No, my organization is not currently leveraging value-based provider arrangements to incentivize the reduction of health disparities
	9.0%	Blank
If incentives are included in your value-based provider arrangements to improve health disparities, what specific Social Determinants of Health (SDoH) or delivery strategies are targeted for	53.0%	Screening for socioeconomic barriers to health
	30.0%	Multidisciplinary team models (e.g., social worker, community health worker, medical staff, doulas, etc.)
	55.0%	Referrals to community-based organizations to address socioeconomic barriers
	45.0%	Data that tracks whether services were received (e.g., closed loop referrals)
	55.0%	Care coordination for services that address socioeconomic barriers

[8] Responses to this question are listed in the order they appeared in the survey. In the 2020 Infographic, the responses are in order from highest to lowest to aid in visual comprehension.

ADDITIONAL INFORMATIONAL QUESTIONS IN 2021 MEASUREMENT SURVEY ONLY		
improvement or enhancement? Check all that apply.	47.0%	Food insecurity (e.g., offering resources for access to nutritious food)
	43.0%	Safe transportation (e.g., incentives or partnerships in ride sharing programs)
	42.0%	Housing insecurity (e.g., provider sponsored housing after a hospital discharge)
	35.0%	Economic insecurity (e.g., connections to job placement or training services)
	33.0%	Social isolation and loneliness (e.g., peer connection programs, group meetings, etc.)
	33.0%	Other basic needs (e.g., providing clothing, diapers, or gift cards; helping with utilities or childcare; providing digital devices such as phones to access telehealth and thrive in new digital world, etc.)
	28.0%	Other
	45.0%	Blank

Commercial

The commercial data, representing 56% of the national market in 2019 and 62% in 2020,[9] shows the following for payments made to providers in CY 2019 and CY 2020:

CATEGORY	CY 2019	CY 2020
CATEGORY 1	TOTAL 53.5%	TOTAL 51.5%
CATEGORY 2	TOTAL 14.4%	TOTAL 13.0%
• Foundational payments to improve care (2A)	SUBTOTAL 0.2%	SUBTOTAL 0.3%
• Fee-for-service plus pay-for-reporting (2B)	SUBTOTAL 0.0%	SUBTOTAL 0.0%
• Fee-for-service plus pay-for-performance payments (2C)	SUBTOTAL 14.2%	SUBTOTAL 12.7%
CATEGORY 3	TOTAL 28.7%	TOTAL 32.1%
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 21.0%	SUBTOTAL 24.7%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	SUBTOTAL 7.7%	SUBTOTAL 7.4%
CATEGORY 4	TOTAL 3.4%	TOTAL 3.4%
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 1.6%	SUBTOTAL 1.0%
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	SUBTOTAL 1.4%	SUBTOTAL 1.6%
• Integrated finance and delivery system programs (4C)	SUBTOTAL 0.4%	SUBTOTAL 0.8%

[9] See footnotes 3 and 4.

CATEGORY	CY 2019	CY 2020
CATEGORIES 3 & 4, COMBINED	TOTAL 32.1%	TOTAL 35.5%
CATEGORIES 3B & 4, COMBINED	TOTAL 11.1%	TOTAL 10.8%

Medicaid

The Medicaid data, representing 55.0% of the national Medicaid market (*excluding* enrollees who are dually eligible for Medicare and Medicaid coverage) in 2019 and 64% in 2020,[10] shows the following for payments made to providers in CY 2019 and CY 2020:

CATEGORY	CY 2019	CY 2020
CATEGORY 1	TOTAL 57.6%	TOTAL 59.0%
CATEGORY 2	TOTAL 6.8%	TOTAL 5.5%
• Foundational payments to improve care (2A)	SUBTOTAL 0.4%	SUBTOTAL 0.2%
• Fee-for-service plus pay-for-reporting (2B)	SUBTOTAL 0.0%	SUBTOTAL 0.2%
• Fee-for-service plus pay-for-performance payments (2C)	SUBTOTAL 6.4%	SUBTOTAL 5.1%
CATEGORY 3	TOTAL 29.4%	TOTAL 29.1%
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 25.0%	SUBTOTAL 21.0%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	SUBTOTAL 4.4%	SUBTOTAL 8.1%

[10] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," July 2021. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts. Accessed November 15, 2021. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," November 2020. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics. Accessed November 15, 2021.

CATEGORY	CY 2019	CY 2020
CATEGORY 4	TOTAL 6.2%	TOTAL 6.4%
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 3.0%	SUBTOTAL 2.3%
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	SUBTOTAL 3.2%	SUBTOTAL 4.0%
• Integrated finance and delivery system programs (4C)	SUBTOTAL 0.0%	SUBTOTAL 0.1%
CATEGORIES 3 & 4, COMBINED	TOTAL 35.6%	TOTAL 35.5%
CATEGORIES 3B & 4, COMBINED	TOTAL 10.6%	TOTAL 14.5%

Medicare Advantage

The Medicare Advantage data, representing 59% of the national Medicare Advantage market in (*including* enrollees who are dually eligible for Medicare and Medicaid coverage) in 2019 and 67% in 2020,[11] shows the following for payments made to providers in CY 2019 and CY 2020:

CATEGORY	CY 2019	CY 2020
CATEGORY 1	TOTAL 46.0%	TOTAL 38.0%
CATEGORY 2	TOTAL 4.0%	TOTAL 4.0%
• Foundational payments to improve care (2A)	SUBTOTAL 0.0%	SUBTOTAL 0.2%

[11] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," July 2021. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts. Accessed November 15, 2021. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," November 2020. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics. Accessed November 15, 2021.

CATEGORY	CY 2019	CY 2020
• Fee-for-service plus pay-for-reporting (2B)	SUBTOTAL 0.0%	SUBTOTAL 0.0%
• Fee-for-service plus pay-for-performance payments (2C)	SUBTOTAL 4.0%	SUBTOTAL 3.8%
CATEGORY 3	TOTAL 28.4%	TOTAL 36.2%
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 21.4%	SUBTOTAL 28.7%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	SUBTOTAL 7.0%	SUBTOTAL 7.5%
CATEGORY 4	TOTAL 21.6%	TOTAL 21.8 %
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 2.2%	SUBTOTAL 1.5%
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	SUBTOTAL 17.7%	SUBTOTAL 18.4%
• Integrated finance and delivery system programs (4C)	SUBTOTAL 1.7%	SUBTOTAL 1.9%
CATEGORIES 3 & 4, COMBINED	TOTAL 50.0%	TOTAL 58.0%
CATEGORIES 3B & 4, COMBINED	TOTAL 28.6%	TOTAL 29.3%

Traditional Medicare

The Traditional Medicare data, representing 38,700,000 Traditional Medicare beneficiaries, which is 100% of the Traditional Medicare market,[12] shows the following for payments made to providers in CY 2019 and CY 2020:

CATEGORY	CY 2019	CY 2020
CATEGORY 1	**TOTAL 14.1%**	**TOTAL 15.0%**
CATEGORY 2	**TOTAL 44.0%**	**TOTAL 42.2%**
CATEGORY 3	**TOTAL 37.4%**	**TOTAL 37.8%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	**SUBTOTAL 21.7%**	**SUBTOTAL 18.6%**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	**SUBTOTAL 15.7%**	**SUBTOTAL 19.2%**
CATEGORY 4	**TOTAL 4.5%**	**TOTAL 5.0%**
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	**SUBTOTAL 3.3%**	**SUBTOTAL 3.5%**
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	**SUBTOTAL 1.2%**	**SUBTOTAL 1.5%**
• Integrated finance and delivery system programs (4C)	**SUBTOTAL 0.0%**	**SUBTOTAL 0.0%**
CATEGORIES 3 & 4, COMBINED	**TOTAL 41.9%**	**TOTAL 42.8%**
CATEGORIES 3B & 4, COMBINED	**TOTAL 20.2%**	**TOTAL 24.2%**

[12] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," July 2021. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts. Accessed November 15, 2021.

Limitations

Health Plan and State Participation Is Voluntary: The LAN data, combined with the AHIP, BCBSA, and Traditional Medicare data reported at the subcategory level, represents 72.5% of the covered lives in the United States in 2019 and 80.2% in 2020. The Measurement Effort did not have full participation from all health plans and states, nor did it capture 100% of the lives covered by health insurance. Furthermore, health plan and state participation in the LAN, BCBSA, or AHIP surveys was voluntary. As a result, the findings may be biased by self-selection. Health plans and states actively pursuing payment reform may have been more likely to respond to the surveys, potentially driving Categories 2-4 results upward.

Potential Variation in the Interpretation of the Metrics: The LAN worked to facilitate a consistent interpretation of the APM categories, subcategories, and terms, as well as the methods for reporting through precise definitions, training sessions, written instructions, and discussions with individual health plans and states seeking clarification. However, the varying interpretation of the metrics could still create variability across data from individual health plans and states.

Data System Challenges: Some health plans and states reported data system challenges with reporting payment dollars according to the APM Framework, because developing new system queries and sorting data according to the APM categories and subcategories can be cumbersome. Such data system limitations can also result in health plans reporting data from an earlier 12-month period than CY 2019/2020, which could reflect lower levels of APM adoption.

Classification of COVID-19 Stabilization and/or Retainer Payments: After the 2021 Measurement Effort started, the LAN received questions from participating health plans and states as to where stabilization and retainer payments paid to providers during the 2020 reporting period should be classified. The LAN issued guidance to participating health plans and states in email correspondence and during the data collection midpoint check-in session to classify these payments in Category 2A. The LAN updated the Frequently Asked Questions to reflect this guidance, and the LAN also shared the guidance with AHIP and BCBSA so they could provide consistent information to their member plans. Despite these actions, it is possible that plans either omitted these payments from their data submission or classified it in categories other than 2A.

NOTICE

Appendix A: Definitions

The following terms and definitions were developed to provide consistent guidance for survey respondents. Some of the definitions are generally accepted, and others are specific only to the LAN and this APM measurement effort.

Table 4: Definitions

TERMS	DEFINITIONS
Alternative Payment Model (APM)	Healthcare 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, and 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 that are **not** adjusted to account for infrastructure investments, provider reporting of quality data, or provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.

TERMS	DEFINITIONS
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.
Category 3	 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 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.

TERMS	DEFINITIONS
Commercial Line of Business	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 is considered commercial and included in the survey. Survey data reflects dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019/2020 or the most recent 12-month period for which data is available. Spending for dental and vision services are excluded.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants.
Condition-specific bundled/episode payments	A single payment to providers and/or healthcare 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**]
Condition-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. [APM Framework Category **4A**]
CY 2019/2020 or most recent 12 months	Calendar year (CY) 2019/2020 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 retrospective "look-back."

TERMS	DEFINITIONS
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients who 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 (FFS)	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 **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**]
Integrated finance and delivery system programs	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**]

TERMS	DEFINITIONS
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 Line of Business	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 excludes the following: healthcare spending for dual eligible beneficiaries, healthcare spending for long-term services and supports (LTSS), and spending for dental and vision services. Survey data reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019/2020 or the most recent 12-month period for which data is available.
Medicare Advantage Line of Business	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 included this information in its response. Survey data reflect dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2019/2020 or the most recent 12-month period for which data is available. Dental and vision services are excluded.

TERMS	DEFINITIONS
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**]
Population-based payment 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 healthcare 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 the APM Measurement Effort, provider includes all providers for which there is healthcare 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.
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 Category **3B**]

TERMS	DEFINITIONS
Total Dollars	The total estimated in- and out-of-network healthcare spend (e.g., annual payment amount) made to providers in CY 2019/2020 or the most recent 12 months for which data is available.
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. [APM Category Framework **3A**]
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. [APM Category Framework **3A**]

Appendix B: About the Health FFRDC

The CMS Alliance to Modernize Healthcare federally funded research and development center (Health FFRDC) accelerates innovation by connecting people and data to reinvent health systems, enhance the care experience, and protect and promote health and well-being. Sponsored by the Centers for Medicare & Medicaid Services (CMS) on behalf of Department of Health and Human Services (HHS), the Health FFRDC serves as an objective advisor to all HHS organizations and other federal agencies with health and human services missions. As operator of the Health FFRDC, MITRE mobilizes experts and convenes stakeholders to pioneer together for the public good, bringing innovative ideas into existence to improve the health and well-being of the nation.