APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS

Methodology and Results Report

2018

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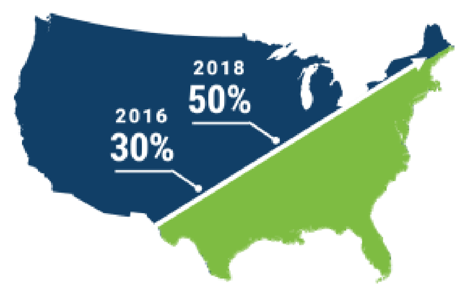
Overview

Alternative payment models (APMs) have the potential to realign payment incentives and care delivery to improve health care quality while reducing costs. In 2015, the U.S. Department of Health and Human Services (HHS) announced a goal of tying 30% of fee-for-service (FFS) Medicare payments to quality or value through APMs by 2016 and 50% by 2018. These goals are expected to accelerate the adoption and dissemination of meaningful financial incentives that reward providers who deliver higher value care.

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 these goals to the LAN's ongoing initiative. Two 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 APM Measurement Effort described in this report marks the third year of this initiative.



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

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Figure 1: LAN APM Framework

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A **Foundational Payments for Infrastructure & Operations** (e.g., care coordination fees and payments for HIT investments)	A **APMs with Shared Savings** (e.g., shared savings with upside risk only)	A **Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B **Pay for Reporting** (e.g., bonuses for reporting data or penalties for not reporting data)	B **APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B **Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C **Pay-for-Performance** (e.g., bonuses for quality performance)		C **Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

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All three 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. In 2017, the results demonstrated the following for payments made during CY 2016:

- 43% of health care dollars in Category 1
- 28% of health care dollars in Category 2
- 29% of health care dollars in a composite of Categories 3 and 4.

A total of 78 health plans and three FFS Medicaid states, as well as Medicare FFS, participated in last year's effort, representing approximately 245.4 million of the nation's covered lives, and 84% of the national market. More information on 2016 payment results can be found in last year's APM Measurement Effort report.

This Year's APM Measurement Effort

To determine the best method of data collection for the 2018 APM Measurement Effort, the LAN revisited the data collection process used in the past two years. The LAN once again collaborated with America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association (BCBSA), and the Centers for Medicare and Medicaid Services (CMS) requesting look-back data from health plans, states and the Medicare FFS program. This year, all entities agreed to make adjustments to the data collection approach. First, in order to establish consistency with the refreshed LAN APM Framework, which captured recent changes in the market, AHIP, BCBSA, CMS, and the LAN incorporated two new metrics: utilization-based shared savings (added to subcategory 3A) and integrated financial and delivery payments (new subcategory 4C). Second, the four organizations were interested in enhancing the quantitative results with qualitative insights about the trajectory of APMs, so they supplemented the survey with five informational questions about the future of APM adoption. Lastly, the four organizations agreed to collect payment data by line of business (i.e., commercial, Medicaid, Medicare Advantage, and Medicare FFS), rather than across lines of business as they had in prior years, and at the payment level within the various subcategories (e.g., pay-for-performance, shared risk). The organizations believe that this more granular data will provide more actionable insights into the state of APMs in the commercial, Medicaid, Medicare Advantage, and Medicare FFS markets.

In this year's effort, 61 health plans, 3 managed FFS Medicaid states, and Medicare FFS, representing approximately 226.3 million of the nation's covered lives and 77% of the national market participated in the data collection at the subcategory level. Seventy (70) health plans, 3 managed FFS Medicaid states, and Medicare FFS, representing almost 241 million of the nation's covered lives and 82% of the

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national market participated in the data collection at the category level.[1] Both percentages of the national market are based on a denominator of approximately 295 million lives covered by any health insurance plan.[2]

This year's LAN APM Measurement Effort combines data from the BCBSA survey, the AHIP survey, and the LAN survey, in addition to Medicare FFS data, which was submitted separately to the LAN. Health plans, states, and Medicare FFS reported the total dollars paid to providers according to the refreshed LAN APM Framework through the payment methods within the subcategories. With this data, the LAN calculated aggregate results by line of business and at the payment method level by category and subcategory.

Scope

Certain items were not included in the scope of the study but could be considered for future measurement efforts. Specifically, this year's LAN APM Measurement Effort did not include or address the following:

Reporting on Incentives: The LAN is interested in measuring the amount of financial incentives to providers. However, according to health plans, this information is difficult to collect, as incentive payments are often made in the year following the reporting period. Some health plans also indicated challenges with breaking out incentive amounts from any base payment, particularly if they offer multiple forms of incentives to a provider.

How Payments Affect Providers Downstream: The LAN has expressed interest in uncovering how APM incentives flow to individual health care providers. However, this information is also difficult to collect, as health plans do not always know how their contracted health systems, hospitals, and/or physician practices pay individual physicians. We do know; however, that organizations which receive Category 4 payments have widely varying philosophies about the extent to which they pass such payments along to individual providers.

Certain Medicare and Medicaid Services: This APM measurement effort does not include health care spending for Medicaid long-term care services or dual-eligible beneficiaries. However, long-term care plans provide unique services and may be included in future APM measurement efforts. Furthermore, dual-eligible beneficiaries and spending were excluded from Medicaid submissions to mitigate the possibility of double counting but were included in Medicare Advantage submissions. Medicare supplement plans and spending were excluded, as they are not part of Medicare Advantage or the commercial market.

[1] This methodology report provides data at both the category and subcategory level using the different datasets. The infographic representation of the data only shows results using the smaller dataset of subcategory respondents.

[2] https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

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Data Source

To advance our understanding of the depth and breadth of payment innovation, the LAN capitalized on existing networks and forged new partnerships to increase awareness and engage additional health plans and states. In addition to partnering with BCBSA and AHIP, the LAN collaborated with several other associations to invite their respective members to directly participate in this effort and to support recruitment. These organizations included the Association for Community Affiliated Plans (ACAP), the Alliance for Community Health Plans (ACHP), and the National Association of Medicaid Directors (NAMD). The LAN also leveraged its communication tools (e.g., website and newsletter) and events (e.g., LAN Summit) to reach broader audiences and to promote the measurement effort among those health plans and states with existing ties to the LAN.

Health plans had multiple paths to contribute to the LAN APM Measurement Effort. In addition to the LAN, BCBSA and AHIP fielded surveys to their member health plans and structured their queries according to the refreshed LAN APM Framework. A coordinated health plan outreach strategy ensured that health plans only responded to one survey, which avoided issues related to double-counting. All three avenues of data collection requested that health plans report the total dollars paid to providers by line of business and at the subcategory level of payment method.

Additionally, Medicare FFS submitted data to the LAN to be aggregated with health plan and state data.

The LAN Survey

The most recent LAN data collection period started on May 15, 2018, and ended on July 15, 2018. The LAN used metrics to determine the extent of APM adoption, asking health plans and states to report dollars paid in either CY 2017 or in the most recent 12 months for which it had data. Health plan and state participation, as well as individual data, were kept confidential. Health plans participating through the LAN had the opportunity to execute a data sharing agreement with the MITRE Corporation as the operator of the CMS Alliance to Modernize Healthcare (CAMH). In order to maintain HHS' impartiality and participant confidentiality, CAMH, and not HHS, received, analyzed, and aggregated all individual plan and state data. The role of the MITRE Corporation is discussed more fully in Appendix B.

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). CAMH 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 look-back metrics required health plans and states to retrospectively examine the actual payments they made to providers in CY 2017 (or in the most recent 12 months for which it had data) through the different APMs and categorize them accordingly. For APMs in

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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.

The data collected through the LAN survey are described in Table 1 and Table 2.

Table 1: 2018 Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2017 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 2017 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 2017 or most recent 12 months.
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 2017 or most recent 12 months.	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2017 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-performance** payments (linked to quality) in CY 2017 or most recent 12 months.	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 2017 or most recent 12 months.
Total dollars paid in **Category 2** in CY 2017 or most recent 12 months.	Payment Reform – APMs built on fee-for-service linked to quality: Percent of total dollars paid in Category 2.

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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 2017 or most recent 12 months.	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2017 or most recent 12 months.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2017 or most recent 12 months.	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2017 or most recent 12 months.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2017 or most recent 12 months.	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 2017 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2017 or most recent 12 months.	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2017 or most recent 12 months.
Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2017 or most recent 12 months.	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 2017 or most recent 12 months.
Total dollars paid in **Category 3** in CY 2017 or most recent 12 months.	Payment Reform – APMs built on fee-for-service architecture: Percent of total dollars paid in Category 3.

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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 2017 or most recent 12 months.	Condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific, population-based payments (linked to quality) in CY 2017 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2017 or most recent 12 months.	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 2017 or most recent 12 months.
Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2017 or most recent 12 months.	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 2017 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery** programs (linked to quality) in CY 2017 or most recent 12 months.	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 2017 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2017 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

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Table 2: 2018 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
Which APM subcategory do you think will be most impacted?	• Traditional shared savings, utilization-based shared savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments, population-based payments that are not condition-specific (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments (4B) • Integrated finance and delivery 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 • Ability to operationalize • Willingness to take on financial risk • Potential finance impact • Market factors • Other (please list)
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 • Ability to operationalize • Willingness to take on financial risk • Potential finance impact • Market factors • Other (please list)

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QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, please indicate to what extent you agree, 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 health care providers (strongly disagree, disagree, agree, strongly agree, not sure) • Higher unit prices (strongly disagree, disagree, agree, strongly agree, not sure) • Other (please list) (strongly disagree, disagree, agree, strongly agree, not sure)

The Blue Cross Blue Shield Association Survey

BCBSA reported the data elements in Table 1 and Table 2, and those listed below in aggregate to the LAN for the purposes of measuring multi-payer adoption of APMs nationally:

- Total number of participating plans, and
- Total number of covered lives by participating plans.

BCBSA collaborated with the LAN and AHIP to ensure alignment of survey questions to facilitate data aggregation.

To collect the data points in Table 1 and Table 2, BCBSA included questions that were aligned with the LAN and AHIP in an annual survey of member plans addressing the delivery of value-based health care. The data elements listed above reflect 2017 data but were submitted to, validated by, and aggregated by BCBSA in the third quarter of 2018. Data were collected for health care spending paid to all providers for dates of service in CY 2017 (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” of December 31, 2017.

The America’s Health Insurance Plans Survey

AHIP worked in collaboration with the LAN to develop an identical survey fielded by both AHIP and the LAN through Qualtrics software (Qualtrics, Provo, UT). In late 2017 and early 2018, the LAN worked with AHIP to design the online survey, based on the metrics described in Tables 1 and 2 above. Questions focused on the dollars associated with APMs, as defined using the refreshed LAN APM Framework. AHIP member plans had the option to respond directly to the LAN or through AHIP. For those plans that submitted to AHIP, AHIP reported the same data elements as did BCBSA to the LAN for the purposes of measuring multi-payer adoption of APMs nationally.

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Starting at the beginning of April, AHIP embarked on a six-week recruitment program, which included repeated email and phone outreach to its member plans. Using a key informant approach, AHIP emailed survey invitations to chief medical officers, provider contracting leads, and payment innovation staff from their member plans, who then shared the survey with their teams, as appropriate. Data collection occurred from May through August 2018 and all responses were based on the plan's business activity during CY 2017.

At the beginning of August, AHIP distributed an abridged version of the survey via email to all non-responding plans. The abridged survey asked plans to report their total health care spending and the distribution of spending by APM category. Enrollment data by line of business (Commercial vs. Medicare Advantage vs. Medicaid Managed Care) for the plans responding to the abridged survey were obtained from the 2017 enrollment data published in the *AIS Directory of Health Plans*. Health spending, both total and by APM category, was apportioned to each line of business in proportion its share of enrollment per the 2017 AIS Directory data. Finally, plans were asked to indicate if they believed that APM activity would increase, stay the same, or decrease over the next 24 months.

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

Medicare Fee-for-Service

The Centers for Medicare & Medicaid Services (CMS) reported Medicare FFS spending in CY 2017 to the LAN. CMS also collaborated with BCBSA, AHIP, and the LAN to align methodologies and facilitate data aggregation for reporting national progress. The CY 2017 Medicare Parts A & 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 Medicare FFS APMs in CY 2017 by subcategory and category.

With the data elements provided, Medicare FFS shows an interim result of 38.3% of payments in Categories 3 and 4 for CY 2017. This result is still considered interim, because it is based on two quarters of CY 2017 actual claims data. Due to claims run out and data lag issues, each quarter of actual claims data is not available until seven to eight months after the previous calendar year.[3]

The alternative payment models CMS used to calculate the percent of payments made through categories 3 and 4 of the APM Framework in CY 2017 include shared savings, shared risk, bundled payments, and population-based payment models. The most recent 2017 CMS Office of the Actuary (OACT) annual Part A and B expenditure data are used to calculate the denominator and are obtained directly from OACT.

[3] The Medicare FFS 2017 interim result will be updated with data from the final two quarters in CY 2016 as part of the President's Budget in the next CMS Congressional Justification, published in 2019.

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Merging the Data

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

To avoid double counting, BCBSA, AHIP, and the LAN coordinated recruiting efforts. BCBSA asked member plans to participate directly through BCBSA, AHIP asked member plans (that were not BCBSA plans) to participate through AHIP or report directly through the LAN. Plans that were members of neither BCBSA nor AHIP had the opportunity to report through the LAN.

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Results: Payments Made in CY 2017

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

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

The combined LAN, BCBSA, AHIP, and Medicare FFS data, representing 77% of the national market[4], show the following subcategory level payments made to providers in CY 2017 in all lines of business:

CATEGORY 1	TOTAL 41%
CATEGORY 2	**TOTAL 25.4%**
• Foundational payments to improve care (2A) • Fee-for-service plus pay for reporting payments (2B) • Fee-for-service plus pay for performance payments (2C)	
CATEGORY 3	**TOTAL 29.8%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 21.1%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B)	SUBTOTAL 8.7%
CATEGORY 4	**TOTAL 3.8%**
• Condition-specific population based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 1.5%
• Full or percent of premium population-based payments (4B)	SUBTOTAL 2.2%
• Integrated finance and delivery programs (4C)	SUBTOTAL 0.1%
CATEGORIES 3 & 4, COMBINED	***TOTAL 33.6%***

[4] 61 health plans, 3 states, Medicare FFS

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INFORMATIONAL QUESTIONS				
PAYERS WHO THINK APM ACTIVITY:	***WILL INCREASE***	***WILL STAY THE SAME***	***WILL DECREASE***	***WHO ARE NOT SURE/DECLINED TO RESPOND***
	90%	9%	0%	1%

PAYERS STATING THAT THE APM SUBCATEGORY MOST IMPACTED WILL BE:	
• Traditional shared-savings, Utilization-based shared savings **(3A)**	**25%**
• Fee-for-service-based shared-risk, Procedure based bundled/episode payments, Population-based payments that are NOT condition specific **(3B)**	**48%**

TOP THREE BARRIERS TO APM ADOPTION AS IDENTIFIED BY PAYERS
1. Willingness to take on financial risk 2. Ability to operationalize 3. Provider interest/readiness

TOP THREE FACILITATORS TO APM ADOPTION AS IDENTIFIED BY PAYERS
1. Health plan interest/readiness 2. Purchaser interest/readiness 3. TIE: Provider interest/readiness & Government influence

PAYERS WHO AGREE OR STRONGLY AGREE WITH AND PAYERS WHO DISAGREE OR STRONGLY DISAGREE WITH THE FOLLOWING:	***AGREE/ STRONGLY AGREE***	***DISAGREE/ STRONGLY DISAGREE***
• APM adoption will result in better quality of care	99%	0%
• APM adoption will result in more affordable care	89%	2%
• APM adoption will result in improved care coordination	97%	1%
• APM adoption will result in more consolidation among health care providers	59%	18%
• APM adoption will result in higher unit prices	6%	73%
• Other (please list)	0%	0%

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Commercial

The commercial data, representing 135,532,277 covered lives, which is 63%[5] of the national commercial market, show the following for payments made to providers in CY 2017:

CATEGORY 1	TOTAL 56.5%
CATEGORY 2	**TOTAL 15.2%**
• Foundational payments to improve care (2A)	SUBTOTAL 0.2%
• Fee-for-service plus pay for reporting (2B)	SUBTOTAL 0%
• Fee-for-service plus pay for performance payments (2C)	SUBTOTAL 15%
CATEGORY 3	**TOTAL 26.6%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 18.4%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B)	SUBTOTAL 8.2%
CATEGORY 4	**TOTAL 1.7%**
• Condition-specific population based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 0.2%
• Full or percent of premium population-based payments (4B)	SUBTOTAL 1.4%
• Integrated finance and delivery programs (4C)	SUBTOTAL 0.1%
CATEGORIES 3 & 4, COMBINED	**TOTAL 28.3%**

[5] https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

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Medicaid

The Medicaid data, representing 31,331,995 Medicaid beneficiaries which is 50% [6] of the national Medicaid market, show the following for payments made to providers in CY 2017:

CATEGORY 1	TOTAL 67.8%
CATEGORY 2	TOTAL 7.2%
• Foundational payments to improve care (2A)	SUBTOTAL 0.1%
• Fee-for-service plus pay for reporting (2B)	SUBTOTAL 0.2%
• Fee-for-service plus pay for performance payments (2C)	SUBTOTAL 6.9%
CATEGORY 3	TOTAL 20.8%
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 17.6%%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B)	SUBTOTAL 3.2%
CATEGORY 4	TOTAL 4.2%
• Condition-specific population based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 1.8%
• Full or percent of premium population-based payments (4B)	SUBTOTAL 2.2%
• Integrated finance and delivery programs (4C)	SUBTOTAL 0.2%
CATEGORIES 3 & 4, COMBINED	TOTAL 25%

[6] https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

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Medicare Advantage

The Medicare Advantage data, representing 20,711,961 Medicare Advantage beneficiaries which is 70%[7] of the national Medicare Advantage market, show the following for payments made to providers in CY 2017:

CATEGORY 1	TOTAL 48%
CATEGORY 2	**TOTAL 2.5%**
• Foundational payments to improve care (2A)	SUBTOTAL 0%
• Fee-for-service plus pay for reporting (2B)	SUBTOTAL 0%
• Fee-for-service plus pay for performance payments (2C)	SUBTOTAL 2.5%
CATEGORY 3	**TOTAL 39.2%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 25.3%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B)	SUBTOTAL 13.9%
CATEGORY 4	**TOTAL 10.3%**
• Condition-specific population based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 1.2%
• Full or percent of premium population-based payments (4B)	SUBTOTAL 9%
• Integrated finance and delivery programs (4C)	SUBTOTAL 0.1%
CATEGORIES 3 & 4, COMBINED	***TOTAL 49.5%***

[7] https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/ and https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html

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Medicare FFS

The Medicare FFS data show the following for payments made to providers in CY 2017:

CATEGORY 1	TOTAL 10.5%
CATEGORY 2	TOTAL 51.2%
CATEGORY 3	TOTAL 33.8%
• Traditional shared-savings, Utilization-based shared-savings (3A)	SUBTOTAL 24.6%
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments, Population-based payments that are NOT condition-specific (3B)	SUBTOTAL 9.2%
CATEGORY 4	*TOTAL 4.5%*
• Condition-specific population based payment, Condition-specific bundled/episode payments (4A)	SUBTOTAL 3.4%
• Full or percent of premium population-based payments (4B)	SUBTOTAL 1.1%
• Integrated finance and delivery programs (4C)	SUBTOTAL 0%
CATEGORIES 3 & 4, COMBINED	TOTAL 38.3%

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

The combined LAN, BCBSA, AHIP, and Medicare FFS data, representing 240,827,558 covered lives or 82% of the national market[8], show the following category level payments made to providers in CY 2017 in all lines of business:

CATEGORY 1	*43%*
CATEGORY 2	*24%*
CATEGORY 3	*29%*
CATEGORY 4	*4%*
CATEGORIES 3 & 4, COMBINED	*33%*

Limitations

Health Plan and State Participation is Voluntary: While the LAN data, combined with the BCBSA, AHIP, and Medicare FFS data reported at the subcategory level, represent 77% of the covered lives in the U.S., the effort neither had full participation from all health plans and states in the U.S. nor captured 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 results upward in Categories 2-4.

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 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 2017, which could reflect a lower level of APM adoption.

[8] 70 health plans, 3 states, Medicare FFS

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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 3: Definitions

TERMS	DEFINITIONS
Alternative Payment Model (APM)	Health care payment methods that use financial incentives to promote or leverage greater value - including higher quality care at lower costs - for patients, purchasers, payers, and providers. This definition is specific to this exercise. If you are interested in MACRA's definition, please reference MACRA for more details. 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 that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.

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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	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.
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

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TERMS	DEFINITIONS
	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 2017 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 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**]
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 2017 or most recent 12 months	Calendar year 2017 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."
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.

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TERMS	DEFINITIONS
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 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. The finance and delivery arms work in tandem to ensure that effective delivery investments are being made and that incentives and strategies within the organization are properly aligned. [APM Framework Category **4C**]
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

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TERMS	DEFINITIONS
	care measures." See definition of "appropriate care measures" for a description and examples.
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 2017 or the most recent 12-month period for which data is available. Dental and vision services are excluded.
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: health care spending for dual eligible beneficiaries, health care spending for long-term care (LTC), spending for dental and vision services. Survey data reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2017 or the most recent 12-month period for which data is available.
Pay-for-performance	The use of incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. [APM Framework Categories **2C** & **2D**]
Population-based payment 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 be, for example, primary

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TERMS	DEFINITIONS
	care services or professional services that are not specific to any particular condition. [APM Framework Category **3B**]
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g., hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **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.
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**].
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in calendar year (CY) 2016 or most recent 12 months.
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

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TERMS	DEFINITIONS
	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 CMS Alliance to Modernize Healthcare

The Centers for Medicare & Medicaid Services (CMS) sponsor the CMS Alliance to Modernize Healthcare (CAMH), the first federally funded research and development center (FFRDC) dedicated to strengthening our nation's healthcare system. The CAMH FFRDC enables CMS, the Department of Health and Human Services (HHS), and other government entities to access unbiased research, advice, guidance, and analysis to solve complex business, policy, technology, and operational challenges in health mission areas. The FFRDC objectively analyzes long-term health system problems, addresses complex technical questions, and generates creative and cost-effective solutions in strategic areas such as quality of care, new payment models, and business transformation.

Formally established under Federal Acquisition Regulation (FAR) Part 35.017, FFRDCs meet special, long-term research and development needs integral to the mission of the sponsoring agency—work that existing in-house or commercial contractor resources cannot fulfill as effectively. FFRDCs operate in the public interest, free from conflicts of interest, and are managed and/or administered by not-for-profit organizations, universities, or industrial firms as separate operating units. The CAMH FFRDC applies a combination of large-scale enterprise systems engineering and specialized health subject matter expertise to achieve the strategic objectives of CMS, HHS, and other government organizations charged with health-related missions. As a trusted, not-for-profit adviser, the CAMH FFRDC has access, beyond what is allowed in normal contractual relationships, to government and supplier data, including sensitive and proprietary data, and to employees and government facilities and equipment that support health missions.

CMS conducted a competitive acquisition in 2012 and 2018 and awarded the CAMH FFRDC contract to The MITRE Corporation (MITRE). MITRE operates the CAMH FFRDC in partnership with CMS and HHS, and maintains a collaborative alliance of partners from nonprofits, academia, and industry. This alliance provides specialized expertise, health capabilities, and innovative solutions to transform delivery of the nation's healthcare services. Government organizations and other entities have ready

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access to this network of partners. This includes select qualified small and disadvantaged business. The FFRDC is open to all CMS and HHS Operating Divisions and Staff Divisions. In addition, government entities outside of CMS and HHS can use the FFRDC with permission of CMS, CAMH's primary sponsor.

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