APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS

Methodology Report

HCP LAN
Health Care Payment Learning & Action Network

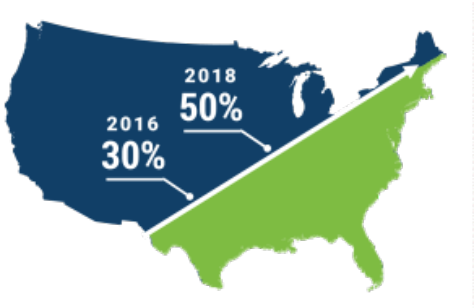
2017

Contents

Overview

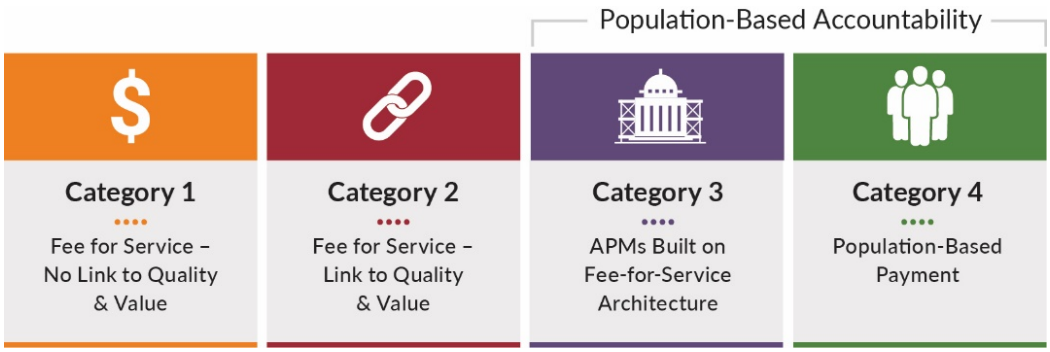
Alternative payment models (APMs) have the potential to realign treatment and payment incentives to improve health care quality while containing cost. In 2015, the U.S. Department of Health and Human Services (HHS) announced a goal of tying 30% of fee-for-service (FFS) Medicare payments to quality or value through APMs by 2016 and 50% by 2018. These goals are expected to accelerate the adoption and dissemination of meaningful financial incentives in order to reward providers delivering 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, also adopted and applied quantitative goals across the U.S. health care system. Last year, 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 LAN's goals and examine how APM adoption is changing over time. The LAN APM Measurement Effort described in this report marks the second 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 original LAN APM Framework using the LAN survey tool, definitions, and methodology.

Figure 1: Original APM Framework



Both LAN APM Measurement Efforts requested health plans to provide data on a look-back basis, a retrospective report 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 last year's effort, when the LAN combined this data with that of the Blue Cross Blue Shield Association (BCBSA), and America's Health Insurance Plans (AHIP), the results demonstrated the following for payments made during CY 2015:

- 62% of health care dollars in Category 1
- 15% of health care dollars in Category 2
- 23% of health care dollars in a composite of Categories 3 and 4

A total of 70 health plans and two FFS Medicaid states participated in last year's effort, representing approximately 199 million of the nation's covered lives, and 67% of the national market (excluding FFS Medicare). More information on 2015 payment results can be found in last year's APM Measurement Effort report.

This Year's APM Measurement Effort

The LAN revisited the data collection process used last year. The LAN once again collaborated with BCBSA and AHIP, who requested look-back data from their member plans. To minimize the data collection burden on health plans and states, and maximize the potential insights, the LAN decided to collect the look-back metrics as well.

In this year's effort, 78 health plans and three managed FFS Medicaid states participated, as well as FFS Medicare, representing approximately 245.4 million of the nation's covered lives and 84% of the national market. This percentage is based on a denominator of approximately 292 million lives covered by any health insurance plan.[1] This year's LAN APM Measurement Effort combines data from the LAN survey, the BCBSA survey, and the AHIP survey as well as FFS Medicare. Health plans, states, and FFS Medicare reported the total dollars paid to providers according to the original APM Framework through different levels of detail, based on the survey in which they participated. With this data, the LAN calculated aggregate results for Category 1, Category 2, and a composite of Categories 3 and 4, to compare the number to the goals. These dollar amounts are the numerators that are divided by the total in- and out-of-network health care spending reported by participating health plans and states (the denominator).

Scope

Certain items were not included in the scope of the study, but will 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 would be interested in measuring the intensity and amount of the 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 also 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.

Certain Medicaid Services: This APM measurement effort does not include health care spending for Medicaid long-term care services or dual-eligible beneficiaries. Long-term care plans provide unique services and may be included in future APM measurement efforts. Dual-eligible plans were excluded due to the difficulty of separating the streams of payment from Medicare and Medicaid and the potential for double counting.

[1] https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf

Updates from the 2017 LAN Framework Refresh Paper: For timing and trend reasons, this year's measurement effort used the original Framework. Changes in the categories and subcategories reflected in the refreshed APM Framework will be incorporated in future measurement efforts.

Data Source

To advance our understanding of the depth and breadth of payment innovation, the LAN invited health plans and FFS Medicaid states to join the LAN in this critical APM measurement effort. The LAN capitalized on existing networks and forged new partnerships to increase awareness and engage health plans and states. In addition to partnering with AHIP and BCBSA, 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 (managed FFS Medicaid states only participated in the LAN survey). In addition to the LAN, AHIP and BCBSA fielded surveys to their member health plans and structured their queries according to the APM Framework. All three avenues of data collection requested that health plans report the total dollars paid to providers through Category 1, Category 2, and a composite of Categories 3 and 4.

Health plans and states submitting data directly to the LAN were given the option to report dollars paid at the level of the various payment models (e.g., fee-for-service, pay-for-performance, shared savings) within subcategories and by market segment.

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

The LAN Survey

The LAN data collection period started on June 28, 2017, and ran through August 14, 2017. The LAN used look-back metrics to determine the extent of APM adoption, asking health plans and states to report dollars paid in either CY 2016 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).[2] In order to maintain HHS' impartiality and participant confidentiality, CAMH, 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). The LAN 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.

[2] The CMS Alliance to Modernize Healthcare (CAMH) is a Federally Funded Research and Development Center (FFRDC), convened to independently manage the LAN.

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 2016 (or in the most recent 12 months for which it had data) through the different APMs and categorize them accordingly. For the 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.

The metrics collected through the LAN survey are described in Table 1.

Table 1: Look-Back Metrics[3]

Numerator	Denominator	Metric
N/A	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Denominator to inform the metrics below.
Alternative Payment Model Framework – Category 1 (Metrics are NOT linked to quality)		
Total dollars paid to providers through **legacy payments (including FFS without a quality component and diagnosis-related groups (DRGs))** in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component, DRGs, and capitation without quality) in CY 2016 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 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2016 or most recent 12 months.
Total dollars paid to providers through **FFS plus P4P payments** (linked to quality) in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2016 or most recent 12 months.

[3] Most plans reported data in more than one market segment. Metrics were identical for each market segment.

Numerator	Denominator	Metric
Total dollars paid in Category 2 in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.
Alternative Payment Model Framework – Category 3 (All metrics are linked to quality)		
Total dollars paid to providers through **FFS-based shared-savings** (linked to quality) payments in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in CY 2016 or most recent 12 months.
Total dollars paid to providers through **FFS-based shared-risk** (linked to quality) payments in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Dollars in shared-risk (linked to quality) programs: Percent of total dollars paid through FFS-based shared-risk payments in CY 2016 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 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 2016 or most recent 12 months.
Total dollars paid to providers through **population-based payments that are not condition-specific (linked to quality)** in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Population-based payments to providers that are not condition-specific (linked to quality): Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in CY 2016 or most recent 12 months.
Total dollars paid in Category 3 in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.

Numerator	Denominator	Metric
Alternative Payment Model Framework – Category 4 (All metrics are linked to quality)		
Total dollars paid to providers through **population-based payments for conditions (linked to quality)** in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2016 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments (linked to quality)** in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 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-based payments linked to quality in CY 2016 or most recent 12 months.
Total dollars paid to providers through **full or percent of premium population-based payments (linked to quality)** in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 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 2016 or most recent 12 months.
Total dollars paid in Category 4 in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.

Numerator	Denominator	Metric
Aggregated Metrics (Comparison between Category 1, Categories 2-4, and Categories 3 & 4)		
Total dollars paid to providers through **legacy payments (including FFS without a quality component and DRGs)** payments in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component, DRGs, and capitation without quality).
Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months.
Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.	Total dollars paid to providers (in- and out- of network) for members in CY 2016 or most recent 12 months.	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.

The Blue Cross Blue Shield Association Survey

BCBSA reported the data elements listed below to the LAN for the purposes of measuring multi-payer adoption of APMs nationally:

- The number of participating plans
- The total number of covered lives by participating plans
- APM Category 1: total dollars
- APM Category 2: total dollars
- APM Categories 3 and 4: total dollars
- Aggregated total dollars in all Categories

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

To collect these data points, 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 2016 data but were submitted to, validated by, and aggregated by BCBSA in the third quarter of 2017. Data were collected for health care spending paid to all providers for dates of service in CY 2016 (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": December 31, 2016.

The America's Health Insurance Plans Survey

AHIP worked in collaboration with BCBSA and the LAN to develop a subset of the questions in AHIP's annual survey. Questions focused on the dollars associated with APMs, as defined using the LAN APM Framework. Using a key informant approach, AHIP emailed 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. Responses were based on dates of service in CY 2016. Data were collected using a web-based survey instrument generated through Qualtrics software (Qualtrics, Provo, UT). After responses were received, AHIP contacted health plans with follow up questions for clarifications and any updates to the data, as appropriate. Some of AHIP member plans responded to the survey while also sharing data with the LAN or BCBSA. AHIP worked with the LAN and BCBSA to ensure that aggregated data shared with the LAN included information from plans that only responded to AHIP to avoid double-counting.

Fee-for-Service Medicare

The Centers for Medicare & Medicaid Services (CMS) reported FFS Medicare spending in CY 2016 to the LAN. CMS also collaborated with the LAN, AHIP, and BCBSA to align methodologies and facilitate data aggregation for reporting national progress. The CY 2016 Medicare Part A & B data elements that were reported to the LAN include:

- Total number of Medicare Part A & B beneficiaries
- Aggregated total dollars in Category 1 (numerator)
- Aggregated total dollars in Category 2 (numerator)
- Aggregated total dollars in Category 3 (numerator)
- Aggregated total dollars in Category 4 (numerator)
- Aggregated total dollars in Categories 3 and 4 combined (numerator)
- Aggregated total dollars in all Categories (denominator)

For this effort, FFS Medicare provided an interim result—31.2% of payments in Categories 3 & 4—which is based on two quarters of data in CY 2016, compared to the 2016 Part A and B expenditure data available to the Office of the Actuary (OACT).[4] The payment models CMS used to calculate the percent of payments made through categories 3 and 4 of the APM Framework in CY 2016 include shared savings, shared risk, bundled payments, and population-based payment models. The most recent 2016 CMS OACT annual Part A and B expenditure data are used to calculate the denominator and are obtained directly from OACT.

Merging the Data

The LAN merged several data elements from the BCBSA and AHIP surveys, as well as those reported by FFS Medicare, with those gathered directly by the LAN. The merged data elements include the total number of health plans and states participating, the total number of lives covered, the aggregated total dollars in Category 1 (numerator), the aggregated total dollars in Category 2 (numerator), the aggregated total dollars in a composite of Categories 3 and 4 (numerator), and the aggregated total dollars in all categories (denominator).

[4] This FFS Medicare 2016 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 2018.

To avoid double counting, the LAN provided a list of health plans participating in its APM measurement effort to BCBSA and AHIP. The associations agreed not to share the LAN list with member health plans or others. The associations then compared the list of health plans participating in the LAN survey to the list of plans participating in their own survey to identify the plans that participated in more than one survey; such plans were removed. In the case of duplicates, the LAN and these trade associations worked together to determine the best way to extract duplicate data so that each health plan's data was counted only once.

Results: Payments Made in CY 2016

The combined LAN, BCBSA, AHIP, and FFS Medicare data, representing 84% of the national market, show the following for payments made to providers in 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

Limitations

Health Plan Participation is Voluntary: While the LAN data, combined with the BCBSA, AHIP, and FFS Medicare data, represent 84% of the covered lives in the U.S., the effort did not have full participation from all health plans in the U.S. or capture 100% of the lives covered by health insurance. Furthermore, health plan participation in the LAN, BCBSA, or AHIP surveys was voluntary. As a result, the findings may be biased by self-selection. Health plans actively pursuing payment reform may have been more likely to respond to the surveys, potentially driving results in Categories 2-4 upward.

Multiple Data Collection Surveys: To both minimize the administrative burden on some health plans and maximize health plan participation, three entities sent surveys to health plans—the LAN, BCBSA, and AHIP. All surveys were based on the original LAN APM Framework, but there were some differences in the surveys. Specifically, the BCBSA survey requested health plans report provider payment data at the APM Framework Category level (i.e., Category 1, Category 2, and Categories 3 & 4 combined), AHIP's survey requested data at the APM Framework Category and Subcategory level (i.e., Categories 1, 2A, 2B, 2C, 2D, and a composite of 3A and 3B and 4A and 4B), and the LAN survey asked health plans to report payments made through specific payment methods within subcategories (e.g., fee-for-service, pay-for-performance, shared savings). In addition, the BCBSA survey asked health plans to report data across all lines of business. The AHIP survey allowed the health plans to either report across all of their lines of business combined or separately, by each line of business. The LAN survey asked health plans and states to report data separately for their commercial, Medicare Advantage, and Medicaid business.

- **Inability to Report Prevalence of Certain Payment Methods:** Results from all three surveys, and the FFS Medicare data, can only be combined at the category level (e.g., Category 2) given that not all surveys collected data at the subcategory (e.g., Category 3A) or payment method level (e.g., shared savings).
- **Inability to Report by Market Segment:** The combined results of the three surveys and FFS Medicare data cannot be reported by market segment given that not all surveys collected data separately for each line of business or market segment. Though the LAN collected data by line of business, these data alone are not representative of each overall market.

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

Health Plan Data System Challenges: Some health plans reported data system challenges with reporting payment dollars according to the APM Framework, as 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 2016.

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 2: 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. Original APM Framework White Paper MACRA Website
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.
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 performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.

Terms	Definitions
Category 4	 Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person- centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care.
Commercial members/ 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**]
CY 2016 or most recent 12 months	Calendar year 2016 or the most current 12-month period for which the health plan can report payment information. This is the reporting period for which the health plan should report all of its "actual" spend data - a 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.

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**]
Legacy payments	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs), and per diems. [APM Framework Category **1**]
Linked to quality	Payments that are set or adjusted based on evidence that providers meet a quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet threshold on cost and quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality."

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** & **2D**]
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. [APM Framework Category **4A**]
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 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.

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

Appendix B: About the CMS Alliance to Modernize Healthcare

The Centers for Medicare & Medicaid Services (CMS) sponsors 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 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 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.