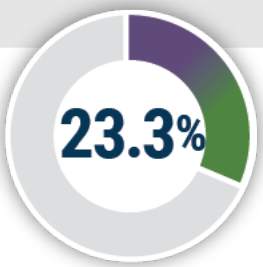
MEDICAID

Commercial health plans, Managed Care Organizations (MCOs), state Medicaid agencies, Medicare Advantage (MA) plans, and Medicare voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

COMMERCIAL

MEDICARE ADVANTAGE

TRADITIONAL MEDICARE



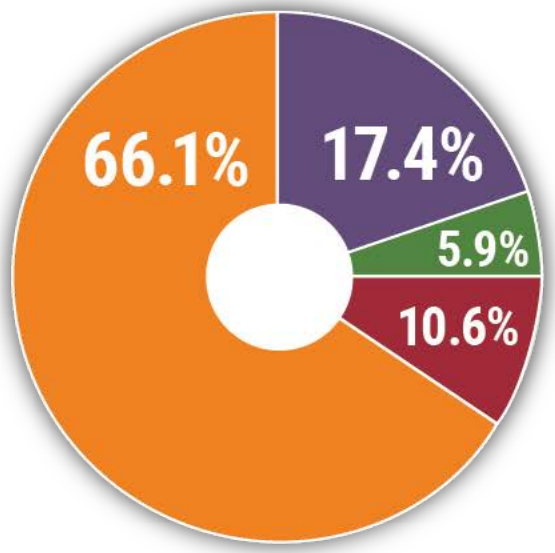
MEDICAID

CATEGORY 1: *FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE*

66.1%

CATEGORY 2: *FEE-FOR-SERVICE – LINK TO QUALITY & VALUE*

1.1%	Foundational Payments for Infrastructure & Operations
<0.1%	Pay-for-Reporting
9.5%	Pay-for-Performance



Representativeness of covered lives: Medicaid (MCOs and state Medicaid Agencies) - 51%

8.3%

Combination of Categories 3B, 4A, 4B, & 4C Represents Two-Sided Risk APMs.

CATEGORY 3: *APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE*

15.0%	Upside Rewards for Appropiate Care
2.4%	Upside & Downside for Appropiate Care

CATEGORY 4: *POPULATION-BASED PAYMENT*

1.9%	Condition-Specific Population-Based Payment
3.9%	Comprehensive Population-Based Payment
0.1%	Integrated Finance & Delivery Systems