Introduction

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

To measure the nation's progress, the LAN launched the National APM Data Collection Effort in 2016. This workbook is used to help health plan prepare their data in order to submit their response to the online survey. The APM Measurement Effort categorizes APM adoption according to the Refreshed APM Framework, which was revised in January 2017, and by line of business to be aggregated with other plan responses.

Refreshed APM Framework Overview

Contents

This workbook is intended for internal use by Measurement Effort participants. To submit APM data to the LAN, please use the online Qualtrics survey.

Tab 6 **Medicaid**	Metrics to report Medicaid dollars flowing through APMs (for either health plans serving the Medicaid sector or state agencies managing health care coverage for state Medicaid enrollees) and metrics to measure covered lives in accountable care
Tab 7 **Cross-Checking**	Questions to identify whether data entries in Tabs 4-6 need correction
Tab 8 **Informational Questions**	Informational questions
Tab 9 **Definitions**	Defines key terms

If you have any questions, please view the Frequently Asked Questions (http://hcp-lan.org/workproducts/APM-Measurement/2023-APM-Measurement-FAQ.pdf) or email Andrea Caballero at acaballero@catalyze.org. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1297. This information collection is to understand the adoption of value-based care and alternative payment models across the health care ecosystem, and this information may inform future efforts and goals in this space. The time required to complete this information collection is estimated to average less than 28 hours per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is voluntary and confidential. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: hcplan@deloitte.com Attention: LAN Operator Team and Andrea Caballero. *Last updated: April 17, 2024.*

General Information

Questions	Responses	
Provide contact name, email, phone, and organization name for the respondent.	Name	
	Email	
	Phone	
	Organization Name	
Please select the lines of business in which your organization operated in 2023. (Select all that apply)	Commercial	
	MA	
	Medicaid	
What is the total number of members covered by the payer by line of business?	Commercial	
	MA	
	Medicaid	
Please list other assumptions, qualifications, considerations, or limitations related to the data submission.		
How many hours did it take your organization to complete this survey by line of business? Please report your response in hours.	Comm	
	MA	
	Medicaid	
My organization (health plan) or agency (state Medicaid agency) agrees to be publicly recognized as a data contributor to the annual measurement effort and the reported APM results. Only the name of the organization will be shared with the LAN and organization responses will remain deidentified	Yes	
	No	

DRAFT REVISED METRICS FOR APM FRAMEWORK
2.17.16

Payment Model Selection

Questions	Responses			
What payment models were in effect in CY 2023? Please specify the line of business.	**Comm**	**MA**	**Medicaid**	
				Cat 1: Legacy Payments
				Cat 2A: Foundational spending to improve care
				Cat 2C: FFS plus Pay for Performance
				Cat 3A: Traditional Shared Savings
				Cat 3A: Utilization-based Shared Savings
				Cat 3B: FFS-based Shared Risk
				Cat 3B: Procedure-based Bundled/Episode Payments
				Cat 4A: Condition-specific Population-based Payments
				Cat 4A: Condition-Specific Bundled/Episode Payments
				Cat 4B: Population-based Payments that are NOT condition-specific
				Cat 4B: Full or Percent of Premium Population-based Payment
				Cat 4C: Integrated Finance and Delivery System Programs

Commercial Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment models (APMs) in calendar year (CY) 2023 or most recent 12 months, as specified.

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

Methods

The metrics should report actual dollars paid through APMs CY 2023 or during the specified time period. For example, if a provider is paid $120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2023, the payments the provider received from January 1, 2023 through June 31, 2023 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2023 through December 31, 2023 ($60,000) would be reported as shared savings, if the reporting period is for CY 2023. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g., on a single day such as December 31, 2023, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received $300 (a combination of $285 base payment plus $15 in shared savings), which, if multiplied by 365 (annualized), would be reported as $109,500 in shared savings CY 2023. An unacceptable approach is counting all of the dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting $120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

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

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

Plans only need to report dollars for the payment models identified in Tab 3 (Payment Model Selection). Accordingly, the online survey uses display logic to only display the payment models selected as "in effect" by the plan respondent.

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2023 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on members attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

#	Numerator/Denominator	Dollar Value	Description of Metric	Metric Calculation
1	Total dollars paid to providers (in and out of network) for commercial members in CY 2023 or most recent 12 months.	$0.00	Denominator to inform the metrics below	
Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for commercial members. 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 2023 or most recent 12 months.	$0.00	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 2023 or most recent 12 months.	#DIV/0!
Alternative Payment Model Framework - Category 2 (Metrics below apply to total dollars paid for commercial members. Metrics are linked to quality).				
3	Dollars paid for foundational spending to improve care (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2023 or most recent 12 months.	#DIV/0!
4	Total dollars paid to providers through fee-for-Service plus pay-for-performance payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2023 or most recent 12 months.	#DIV/0!
5	Total dollars paid in Category 2 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (Metrics below apply to total dollars paid for commercial members. Metrics are linked to quality)				
6	Total dollars paid to providers through traditional shared-savings (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2023 or most recent 12 months.	#DIV/0!

7	Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2023 or most recent 12 months.	#DIV/0!
8	Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in FFS-based shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.	#DIV/0!
9	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs in CY 2023 or most recent 12 months.	$0.00	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2023 or most recent 12 months.	#DIV/0!
10	Total dollars paid in Category 3 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!
Alternative Payment Model Framework - Category 4 (Metrics below apply to total dollars paid for commercial members. Metrics are linked to quality)				
11	Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars in condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2023 or most recent 12 months.	#DIV/0!
12	Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Population-based payments to providers that are not condition-specific and linked to quality: Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in CY 2023 or most recent 12 months.	#DIV/0!
13	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	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 2023 or most recent 12 months.	#DIV/0!
14	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	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 in CY 2023 or most recent 12 months.	#DIV/0!

15	Total dollars paid to providers through integrated finance and delivery system programs (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs in CY 2023 or most recent 12 months.	#DIV/0!
16	Total dollars paid in Category 4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!
Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				
17	Total dollars paid to providers through legacy payments in CY 2023 or most recent 12 months.	$0.00	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component and DRGs).	#DIV/0!
18	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2023 or most recent 12 months.	#DIV/0!
19	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2023 or most recent 12 months.	#DIV/0!

Measuring Covered Lives in Accountable Care APMs Instructions

Goal/Purpose = To measure the percentage of plan members in accountable care APMs in CY 2023 or most recent 12 months, as specified.

Methods

The information for these questions will be used to report the percentage of plan members attributed, aligned, assigned, or empaneled to a primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in a total cost of care (TCOC) accountable care APM of six months or longer in CY 2023 or most recent 12 months.

Plans should use the general guidance below to allocate members to the accountable care APM covered lives questions.

General Guidance on Allocating Health Plan Members to the Accountable Care APM Questions:
Health plans typically attribute health plan members in accountable care APM arrangements to a PCP/PCG. In some situations, health plans/states may attribute members to both a PCP/PCG and a non-PCP (i.e., specialist). In these instances, for the following questions health plans should attribute members to either the PCP/PCG or the non-PCP focused accountable care APM questions but not both.

If your organization attributes members to only the PCP/PCG accountable care APMs, the following applies:

1. Allocating health plan member lives to Category 3 or 4 accountable care APM arrangements
If your organization attributes health plan members to the PCP/PCG focused accountable care APM questions, please attribute your organization's covered lives to Category 3 (i.e., 3A, 3B) and/or Category 4 (i.e., 4A, 4B, 4C). Metric 21, row 52.

If your organization attributes members to only the non-PCP (i.e., specialist) accountable care APMs, the following applies:

1. Allocating health plan member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements
If your organization attributes health plan members to non-PCP (i.e., specialist) focused accountable care arrangements, please attribute your organization's member lives to Category 3 (i.e., 3A,3B) and/or Category 4 (i.e., 4A, 4B, 4C). Metric 22, row 54.

For further guidance, please reference this document (https://hcp-lan.org/workproducts/APM-Measurement/Guidance-for-measuring-covered-lives.pdf) for additional definitional parameters along with inclusion/exclusion criteria. This document provides examples that will help with answering the accountable care questions. Additionally, please refer to the definition section for key terms.

PCP/PCG-Focused Accountable Care Metrics (metrics below apply to th number of commercial plan members in an accountable care arrangements. Metrics are linked to quality)				
20	Total commercial covered lives CY 2023 or most recent 12 months.	0.00	Total commercial covered lives should be the same as the covered lives listed in the General Info tab (row 12)	

21	Total number of commercial health plan members attributed/aligned/assigned/empaneled to a PCP or PCG participating in a total cost of care (TCOC) Category 3 or 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months.	0.00	Percent of commercial plan members attributed/aligned/assigned/empaneled to a primary care provider (PCP) or primary care group (PCG) participating in a total cost of care (TCOC) Category 3 or 4 care APM of six months or longer in CY 2023 or most recent 12 months.	#DIV/0!
Non-PCP/PCG-Focused Accountable Care Metric (metrics below apply to the number of commercial plan members in an accountable care arrangements. Metrics are linked to quality)				
22	Total number of commercial health plan members attributed/aligned/assigned/empaneled to non-PCPs (i.e., specialists) participating in a total cost of care (TCOC) Category 3 or Category 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months. (i.e., any members not captured on Metric 21).	0.00	Percent of commercial plan members attributed/aligned/assigned/empaneled to a participating non-PCPs (i.e., specialists) in a total cost of care(TCOC) Category 3 or Category 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months. (i.e., any members not captured on Metrics 21).	#DIV/0!

Medicare Advantage Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment models (APMs) in calendar year (CY) 2023 or most recent 12 months, as specified.

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

Methods

The metrics should report actual dollars paid through APMs CY 2023 or during the specified time period. For example, if a provider is paid $120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2023, the payments the provider received from January 1, 2023 through June 31, 2023 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2023 through December 31, 2023 ($60,000) would be reported as shared savings, if the reporting period is for CY 2023. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g., on a single day such as December 31, 2023, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received $300 (a combination of $285 base payment plus $15 in shared savings), which, if multiplied by 365 (annualized), would be reported as $109,500 in shared savings CY 2023. An unacceptable approach is counting all of the dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting $120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

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

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

Plans only need to report dollars for the payment models identified in Tab 3 (Payment Model Selection). Accordingly, the online survey uses display logic to only display the payment models selected as "in effect" by the plan respondent.

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2023 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on members attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

#	Numerator/Denominator	Dollar Value	Description of Metric	Metric Calculation

1	Total dollars paid to providers (in and out of network) for Medicare Advantage members in CY 2023 or most recent 12 months.	$0.00	Denominator to inform the metrics below	
Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for MA members. Metrics are NOT linked to quality)				
2	Total dollars paid to providers through legacy payments (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2023 or most recent 12 months.	$0.00	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 2023 or most recent 12 months.	#DIV/0!
Alternative Payment Model Framework - Category 2 (Metrics below apply to total dollars paid for MA members. Metrics are linked to quality).				
3	Dollars paid for foundational spending to improve care (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2023 or most recent 12 months.	#DIV/0!
4	Total dollars paid to providers through fee-for-Service plus pay-for-performance payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2023 or most recent 12 months.	#DIV/0!
5	Total dollars paid in Category 2 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (Metrics below apply to total dollars paid for MA members. Metrics are linked to quality)				
6	Total dollars paid to providers through traditional shared-savings (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2023 or most recent 12 months.	#DIV/0!

7	Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2023 or most recent 12 months.	#DIV/0!
8	Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in FFS-based shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.	#DIV/0!
9	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs in CY 2023 or most recent 12 months.	$0.00	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2023 or most recent 12 months.	#DIV/0!
10	Total dollars paid in Category 3 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!
Alternative Payment Model Framework - Category 4 (Metrics below apply to total dollars paid for MA members. Metrics are linked to quality)				
11	Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars in condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2023 or most recent 12 months.	#DIV/0!

12	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	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 2023 or most recent 12 months.	#DIV/0!
13	Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Population-based payments to providers that are not condition-specific and linked to quality: Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in CY 2023 or most recent 12 months.	#DIV/0!
14	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	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 in CY 2023 or most recent 12 months.	#DIV/0!
15	Total dollars paid to providers through integrated finance and delivery system programs (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs in CY 2023 or most recent 12 months.	#DIV/0!
16	Total dollars paid in Category 4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!
Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				

17	Total dollars paid to providers through legacy payments in CY 2023 or most recent 12 months.	$0.00	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component and DRGs).	#DIV/0!
18	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2023 or most recent 12 months.	#DIV/0!
19	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2023 or most recent 12 months.	#DIV/0!

Measuring Covered Lives in Accountable Care APMs Instructions

Goal/Purpose = To measure the percentage of plan members in accountable care APMs in CY 2023 or most recent 12 months, as specified.

Methods
The information for these questions will be used to report the percentage of plan members attributed, aligned, assigned, or empaneled to a primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in a total cost of care (TCOC) accountable care APM of six months or longer in CY 2023 or most recent 12 months.

Plans should use the general guidance below to allocate members to the accountable care APM covered lives questions.

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General Guidance on Allocating Health Plan Members to the Accountable Care APM Questions:
Health plans typically attribute health plan members in accountable care APM arrangements to a PCP/PCG. In some situations, health plans/states may attribute members to both a PCP/PCG and a non-PCP (i.e., specialist). In these instances, for the following questions health plans should attribute members to either the PCP/PCG or the non-PCP focused accountable care APM questions but not both.

If your organization attributes members to only the PCP/PCG accountable care APMs, the following applies:

1. Allocating health plan member lives to Category 3 or 4 accountable care APM arrangements
If your organization attributes health plan members to the PCP/PCG focused accountable care APM questions, please attribute your organization's covered lives to Category 3 (i.e., 3A, 3B) and/or Category 4 (i.e., 4A, 4B, 4C). Metric 21, row 44.

If your organization attributes members to only the non-PCP (i.e., specialist) accountable care APMs, the following applies:

1. Allocating health plan member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements
If your organization attributes health plan members to non-PCP (i.e., specialist) focused accountable care arrangements, please attribute your organization's member lives to Category 3 (i.e., 3A,3B) and/or Category 4 (i.e., 4A, 4B, 4C). Metric 22, row 46.

For further guidance, please reference this document (https://hcp-lan.org/workproducts/APM-Measurement/Guidance-for-measuring-covered-lives.pdf) for additional definitional parameters along with inclusion/exclusion criteria. This document provides examples that will help with answering the accountable care questions. Additionally, please refer to the definition section for key terms.

PCP/PCG-Focused Accountable Care Metrics (metrics below apply to th number of MA plan members in an accountable care arrangements. Metrics are linked to quality)

20	Total Medicare Advantage covered lives CY 2023 or most recent 12 months.	0.00	Total Medicare Advantage covered lives should be the same as the covered lives listed in the General Info tab (row 12)	
21	Total number of Medicare Advantage health plan members attributed/aligned/assigned/empaneled to a PCP or PCG participating in a total cost of care (TCOC) Category 3 or 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months.	0.00	Percent of Medicare Advantage plan members attributed/aligned/assigned/empaneled to a primary care provider (PCP) or primary care group (PCG) participating in a total cost of care (TCOC) Category 3 or 4 care APM of six months or longer in CY 2023 or most recent 12 months.	#DIV/0!
Non-PCP/PCG-Focused Accountable Care Metric (metrics below apply to the number of MA plan members in an accountable care arrangements. Metrics are linked to quality)				
22	Total number of Medicare Advantage health plan members attributed/aligned/assigned/empaneled to non-PCPs (i.e., specialists) participating in a TCOC Category 3 or Category 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months. (i.e., any members not captured on Metric 21).	0.00	Percent of Medicare Advantage plan members attributed/aligned/assigned/empaneled to a participating non-PCPs (i.e., specialists) in a total cost of care Category 3 or Category 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months. (i.e., any members not captured on Metric 21).	#DIV/0!

Medicaid Metrics

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment models (APMs) in calendar year (CY) 2023 or most recent 12 months, as specified.

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

Methods

The metrics should report actual dollars paid through APMs CY 2023 or during the specified time period. For example, if a provider is paid $120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2023, the payments the provider received from January 1, 2023 through June 31, 2023 ($60,000) would be reported as fee-for-service and the payments the provider received from July 1, 2023 through December 31, 2023 ($60,000) would be reported as shared savings, if the reporting period is for CY 2023. An acceptable approach is annualizing dollars paid in APMs based on a point in time, e.g., on a single day such as December 31, 2023, only if the APM contract existed for the full 12-month period. For example, a provider in a shared savings arrangement received $300 (a combination of $285 base payment plus $15 in shared savings), which, if multiplied by 365 (annualized), would be reported as $109,500 in shared savings CY 2023. An unacceptable approach is counting all of the dollars paid to the provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. considering the first example, counting $120,000 in shared savings even though the contract was only in place for half of the reporting year). NOTE: this method is much more vulnerable to variation from actual spending depending on the representativeness of the time period annualized.

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

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

Plans only need to report dollars for the payment models identified in Tab 3 (Payment Model Selection). Accordingly, the online survey uses display logic to only display the payment models selected as "in effect" by the plan respondent.

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid to providers CY 2023 or most recent 12 months unless another method, such as annualizing, is used. Numerators should not be calculated based on beneficiaries attributed to APMs unless the provider is held responsible for all care (in network, out of network, inpatient, outpatient, behavioral health, pharmacy) the patient receives.

#	Numerator/Denominator	Dollar Value	Description of Metric	Metric Calculation
1	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2023 or most recent 12 months.	$0.00	Denominator to inform the metrics below	

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Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are NOT linked to quality)				
2	Total dollars paid to providers through legacy payments (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2023 or most recent 12 months.	$0.00	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 2023 or most recent 12 months.	#DIV/0!
Alternative Payment Model Framework - Category 2 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are linked to quality).				
3	Dollars paid for foundational spending to improve care (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2023 or most recent 12 months.	#DIV/0!
4	Total dollars paid to providers through fee-for-Service plus pay-for-performance payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2023 or most recent 12 months.	#DIV/0!
5	Total dollars paid in Category 2 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.	#DIV/0!
Alternative Payment Model Framework - Category 3 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are linked to quality)				
6	Total dollars paid to providers through traditional shared-savings (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2023 or most recent 12 months.	#DIV/0!
7	Total dollars paid to providers through utilization-based shared-savings (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2023 or most recent 12 months.	#DIV/0!

8	Total dollars paid to providers through fee-for-service-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.	$0.00	Dollars in FFS-based shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.	#DIV/0!
9	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs in CY 2023 or most recent 12 months.	$0.00	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2023 or most recent 12 months.	#DIV/0!
10	Total dollars paid in Category 3 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!
Alternative Payment Model Framework - Category 4 (Metrics below apply to total dollars paid for Medicaid beneficiaries. Metrics are linked to quality)				
11	Total dollars paid to providers through condition-specific, population-based payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars in condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2023 or most recent 12 months.	#DIV/0!
12	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	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 2023 or most recent 12 months.	#DIV/0!
13	Total dollars paid to providers through population-based payments that are NOT condition-specific (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Population-based payments to providers that are not condition-specific and linked to quality: Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in CY 2023 or most recent 12 months.	#DIV/0!

14	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2023 or most recent 12 months.	$0.00	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 in CY 2023 or most recent 12 months.	#DIV/0!
15	Total dollars paid to providers through integrated finance and delivery system programs (linked to quality) in CY 2023 or most recent 12 months.	$0.00	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs in CY 2023 or most recent 12 months.	#DIV/0!
16	Total dollars paid in Category 4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!
Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				
17	Total dollars paid to providers through legacy payments in CY 2023 or most recent 12 months.	$0.00	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component and DRGs).	#DIV/0!
18	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2023 or most recent 12 months.	#DIV/0!
19	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2023 or most recent 12 months.	$0.00	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2023 or most recent 12 months.	#DIV/0!

Measuring Covered Lives in Accountable Care APMs Instructions

Goal/Purpose = To measure the percentage of plan members in accountable care APMs in CY 2023 or most recent 12 months, as specified.

Methods
The information for these questions will be used to report the percentage of plan members attributed, aligned, assigned, or empaneled to a primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in a total cost of care (TCOC) accountable care APM of six months or longer in CY 2023 or most recent 12 months.

Plans should use the general guidance below to allocate members to the accountable care APM covered lives questions.

General Guidance on Allocating Health Plan Members to the Accountable Care APM Questions:
Health plans typically attribute health plan members in accountable care APM arrangements to a PCP/PCG. In some situations, health plans/states may attribute members to both a PCP/PCG and a non-PCP (i.e., specialist). In these instances, for the following questions health plans should attribute members to either the PCP/PCG or the non-PCP focused accountable care APM questions but not both.

If your organization attributes members to only the PCP/PCG accountable care APMs, the following applies:

1. Allocating health plan member lives to Category 3 or 4 accountable care APM arrangements
If your organization attributes health plan members to the PCP/PCG focused accountable care APM questions, please attribute your organization's covered lives to Category 3 (i.e., 3A, 3B) and/or Category 4 (i.e., 4A, 4B, 4C). Metric 21, row 44.

If your organization attributes members to only the non-PCP (i.e., specialist) accountable care APMs, the following applies:

1. Allocating health plan member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements

1. Allocating health plan member lives to non-PCPs (i.e., specialists) who participate in accountable care APM arrangements
If your organization attributes health plan members to non-PCP (i.e., specialist) focused accountable care arrangements, please attribute your organization's member lives to Category 3 (i.e., 3A, 3B) and/or Category 4 (i.e., 4A, 4B, 4C). Metric 22, row 46.

For further guidance, please reference this document (https://hcp-lan.org/workproducts/APM-Measurement/Guidance-for-measuring-covered-lives.pdf) for additional definitional parameters along with inclusion/exclusion criteria. This document provides examples that will help with answering the accountable care questions. Additionally, please refer to the definition section for key terms.

PCP/PCG-Focused Accountable Care Metrics (metrics below apply to th number of Medicaid plan members in an accountable care arrangements. Metrics are linked to quality)				
20	Total Medicaid covered lives CY 2023 or most recent 12 months.	0.00	Total Medicaid covered lives should be the same as the covered lives listed in the General Info tab (row 12)	
21	Total number of Medcaid plan members attributed/aligned/assigned/empaneled to a PCP or PCG participating in a total cost of care (TCOC) Category 3 or 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months.	0.00	Percent of Medicaid plan members attributed/aligned/assigned/empaneled to a primary care provider (PCP) or primary care group (PCG) participating in a total cost of care (TCOC) Category 3 or 4 care APM of six months or longer in CY 2023 or most recent 12 months.	#DIV/0!
Non-PCP/PCG-Focused Accountable Care Metric (metrics below apply to the number of Medicaid plan members in an accountable care arrangements. Metrics are linked to quality)				

22	Total number of Medicaid health plan members attributed/aligned/assigned/empaneled to non-PCPs (i.e., specialists) participating in a TCOC Category 3 or Category 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months. (i.e., any member not captured on Metric 21).	0.00	Percent of Medicaid plan members attributed/aligned/assigned/empaneled to a participating non-PCPs (i.e., specialists) in a total cost of care Category 3 or Category 4 accountable care APM of six months or longer in CY 2023 or most recent 12 months. (i.e., any members not captured on Metric 21).	#DIV/0!

Cross-Checking

Please take a moment to review your data entry.

The sum of the dollars listed for each payment model (the numerators) should account for exactly 100% of the total dollars paid to providers in 2021 (the denominator). If the sum of the numerators does not equal the denominator, the LAN Measurement Team will email you to identify where dollars are missing or are

Line of Business	Sum of Numerators	Denominator	Review: Is the denominator equal to the sum of the numerators?
Commercial	0	0	Yes or No
Medicare Advantage	0	0	Yes or No
Medicaid	0	0	Yes or No

Common issues for why the sum of the numerators is not equal to the denominator:

If the sum of the numerators is greater than the denominator:

Double counting of APM dollars: When a provider arrangement includes more than one type of payment method, all dollars flowing through that arrangement should be categorized today in the most advanced or "dominant" APM.

If the sum of the numerators is less than the denominator:

Not accounting for the underlying fee-for-service payments: Dollars categorized as an APM Categories 2 and 3 rely on a fee-for-service architecture. Payments classified as APMs should include the underlying fee-for-service payments in addition to any incentives, bonuses, or savings shared with the provider.

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

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2.17.16

Informational Questions

The following questions ask about the current and future state of payment reform from the health plan's perspective.

Questions	Responses	
From health plan's perspective, what do you think will be the trend in APMs over the next 24		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 payments (4C)
[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 payments(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)
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, disagree that APM adoption will result in each		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 for discrete services (strongly disagree, disagree, agree, strongly agree, not sure)
[For payers who operated in more than one LOB]	Yes	Please describe how the answers to the questions above vary by line of business.
	No	
Is your Plan leveraging value-based provider arrangements to incentivize providers to improve health equity through the following strategies? Check all responses that apply.		Collection of standardized race, ethnicity, and language data
		Collection of sexual orientation, gender, and identity data
		Collection of disability status
		Collection of veteran status
		Participation in implicit bias (or similar) training
		Complete staff competencies to serve diverse populations
		Reporting performance measures by race, ethnicity, and language
		Measurement of clinical outcome inequities among member groups
		Reduction of clinical outcome inequities among member groups
		Participation in quality improvement collaboratives
		If other, please specify_____
If incentives are included in your value-based provider arrangements to improve		Screening for socioeconomic barriers known to impact health or health outcomes
		Multidisciplinary team models (e.g. social worker, community health worker, medical staff, doulas, etc.)
		Referrals to community-based organizations to address socioeconomic barriers

social determinants of health, what specific Social Determinants of Health (SDoH) or delivery strategies are intended to improve? Check all that apply.		Verifications of interventions provided
		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.)
		Expanding access to virtual and digital care
		If other, please specify_____
The Health Care Payment and Learning Action Network (HCP-LAN) is interested in learning first-hand from health plans about incentives to address health equity and multi-payer collaboration in APM design and implementation. Is your organization willing to provide additional insights to the LAN about these topics if contacted?	Yes	
	No	
My organization (health plan) or agency (state Medicaid agency) agrees to be publicly recognized as a data contributor to the annual measurement effort and the reported APM results. Only the name of the organization will be shared with the LAN and organization responses will remain de-identified.	Yes	
	No	

Definitions

Terms	Definitions
Accountable Care	Accountable Care centers on the patient and aligns their care team to support shared decision-making and help realize the best achievable health outcomes for all through comprehensive, high quality, affordable, equitable, longitudinal care. For the purposes of the LAN's annual survey, accountable care must include two elements or dimensions: 1) the care is longitudinal with a duration of six months or longer; and 2) the payment model incorporates accountability for total cost of care (TCOC) for aligned patients. See TCOC definition and further clarification along with examples below.
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.
Assign/Assigned/Assignment or Align/Aligned/Alignment	The method by which health plans associate members (individual patients, regardless of product – commercial Medicaid or Medicare Advantage) to a contracted, in-network primary care physician (PCP) or a primary care group (PCG) for the purposes of an accountable care. This term includes a health plan member who chooses (voluntarily, self-designates) a contracted, in-network PCP or PCG. The PCP or PCG is charged with caring for the patients for whom they have been delegated by the contracted health plan. NOTE: Some health plans may have specialty models that assign patients to a specialist based on the model instead of a PCP or PCG. In such cases, the health plan should count these members under Metric #24 – Non-PCP/PCG-Focused Accountable Care Metric. However, if the member is assigned to a specialist and a PCP, the health plan should only count that member one time under either Metrics 21-23 (i.e., PCP/PCG) OR Metric 24 (non-PCP/PCG), but not both. See General Guidance information in the Measuring Covered Lives in Accountable Care section of the Commercial, Medicare Advantage, and Medicaid tabs. See examples of assign/assigned/assignment from the perspective of a health plan or health plan member below. Health Plan Example: Health plans may take this action when the product in which the member enrolls requires the member to select a PCP or PCG. If the member does not select a PCP or PCG at the time of enrollment, the health plan allocates – or assigns – the member to a PCP or PCG within the health plans' preferred provider network. The health plan may consider the PCP or PCG's current panel size, geographic location, member claims' history, and other factors when identifying an appropriate PCP or PCG for the member. Health Member Example: A health plan member may voluntarily select a PCP or PCG at the
Attributed/Attribution	Refers to a statistical or administrative methodology that attributes a patient population to a provider for a particular APM (which must include cost AND quality). "Attributed" patients can include those who choose to enroll in, or do not opt out of, an accountable care organization (ACO), patient centered medical home (PCMH), or other delivery models in which patients are attributed to a provider who is accountable for a patient's total cost of care for six months or longer.

Empanel/Empaneled/Empanelment	This term is typically used in a provider-facing manner; however, some health plans may use this term internally to describe the act the health plan takes to assign individual patients to individual primary care providers (PCP) or primary care groups (PCG) and care teams with sensitivity to patient and family preference. (AHRQ) This act or process results in a provider having a "patient panel." The patient panel is a group of patients assigned to one PCP or primary care group (PCG). The physician and/or group is accountable for the care of the patients within the panel. (Adapted from AHRQ, AMA definitions) Also known as paneled or paneling. See also assign/assigned/assignment.
	Source: AHRQ
Category 1	Fee-for-service with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1.
Category 2	Fee-for-service linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.
Category 3	Alternative payment methods (APMs) built on fee-for-service architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers that who meet their quality, and cost or utilization targets are eligible to share in savings, and those who do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. See definition of "appropriate care measures" for a description and examples.
Category 4	Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.
Commercial Market	For the purposes of this survey, the commercial market segment includes individual, small group, large group, fully insured, self-funded and exchange business. To the extent a health plan provides benefits for the Federal Employee Health Benefit (FEHB) program, state active employee programs, and/or an exchange, this business should be considered commercial and included in the survey. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2023 or the most recent 12-month period for which data is available. Spending for dental and vision services are excluded. See "General Information" tab in the Excel workbook for more information.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants. See Frequently Asked Questions for more information.
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g. diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A**].
Conditions-specific population-based payment	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. See Frequently Asked Questions for more information. [APM Framework Category 4A].

CY 2023 or most recent 12 months	Calendar year 2023 or the most current 12-month period for which the health plan can report payment information. This is the 12 month reporting period for which the health plan should report all of its "actual" spend data - a retrospective "look back."
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**].
Fee-For Service Based Shared risk	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. [APM Framework **3B**].
Foundational spending	Includes but is not limited to payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments and/or per-episode fees for specialists. [APM Framework Category **2A**].
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g. inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B**].
Integrated finance and delivery system payments	Payments in which the delivery system is integrated with the finance system and delivers comprehensive care. These integrated arrangements consist of either insurance companies that own provider networks, or delivery systems that offer their own insurance products, or payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships. See Frequently Asked Questions for more information. [APM Framework Category **4C**].
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.
Longitudinal Relationship	This is defined as a care relationship where the provider has aligned patients in which they serve as a coordinator for their overall care. At minimum, this longitudinal relationship needs to be six (6) months and often can be determined on a yearly basis in alternative payment models. A provider-patient relationship for an episode of care for a chronic condition or cancer treatment regimen that is six months or longer also qualifies as a longitudinal relationship. <u>Exclusions</u>: A three-month episode for a hip/knee replacement or other such service does not qualify as a longitudinal relationship. Plans are asked to exclude these patients from the accountable care count UNLESS the patient is in an accountable care relationship with another provider that is six months or longer.
Medicaid Market	For the purposes of this survey, the Medicaid market segment includes both business with a state to provide health benefits to Medicaid eligible individuals and state-run programs themselves. Data submitted for this survey should exclude the following: health care spending for dual-eligible beneficiaries, health care spending for long-term services and supports (LTSS), spending for dental and vision services. Responses to the survey will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2023 or the most recent 12-month period for which data is available. See “General Information” tab in the Excel workbook for more information.

Medicare Advantage Market	For the purposes of this survey, the Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it should include this information in its response. Responses to the survey will reflect dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2023 or the most recent 12-month period for which data is available. Dental and vision services are excluded. See "General Information" tab in the Excel workbook for more information.
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 payments that are NOT condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could cover primary, acute and post-acute care that is not specific to any particular condition. [APM Framework Category **4B**]
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3B**].
Provider	For the purposes of this workbook, provider includes all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible, and excludes dental and vision.
Total Cost of Care	Total cost of care (TCOC) is intended to indicate there is significant financial accountability for the patient's care; however, it does NOT mean that every claim related to a patient must fall under the TCOC arrangement. In other words, TCOC does not need to include ALL of the patient's costs; it can be a significant subset of a patient's costs. Additionally, TCOC covers inpatient and outpatient services (e.g., Medicare Part A and B) and can potentially include drug costs (e.g., Medicare Part B and D) or other long-term services and supports as desired. Providers do not need to be in a capitated payment arrangement or at financial risk for TCOC spending but have some measure(s) that they are assessed on for TCOC as part of their overall performance (e.g., Primary Care First has a measure on Total Per Capita Cost for aligned beneficiaries), however, capitation arrangements or financial risk for TCOC would also count as accountability for TCOC. See TCOC examples below. Example 1: A TCOC arrangement that excludes drug-benefit-related costs can still be considered a TCOC arrangement. Example 2: A TCOC arrangement that is for a patient's primary care services, but not the patient's specialty or facility-related costs can still be considered a TCOC arrangement. Example 3: An episode-based model of 6-month or longer that excludes un-related services, outliers, and other select exclusionary criteria (e.g., major traumas) can still be considered a TCOC arrangement. Example 4: An arrangement that only covers wellness or preventive care is not considered a TCOC arrangement.
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) 2023 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.

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 provide very strong proxies for 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.