MEDICAID ONLY: GENERAL INFO
DRAFT REVISED METRICS FOR APM FRAMEWORK
4.20.16

Questions	Responses	
Provide contact name, email and phone for the health plan respondent.	Name:	
	Email:	
	Phone:	
What is the total number of Medicaid beneficiaries covered by the health plan?		
In which state(s) does the health plan have business?		Alabama
		Alaska
		Arizona
		Arkansas
		California
		Colorado
		Connecticut
		Delaware
		Florida
		Georgia
		Hawaii
		Idaho
		Illinois
		Indiana
		Iowa
		Kansas
		Kentucky
		Louisiana
		Maine
		Maryland
		Massachusetts
		Michigan
		Minnesota
		Mississippi
		Missouri
		Montana
		Nebraska
		Nevada
		New Hampshire
		New Jersey

Questions	Responses	
		New Mexico
		New York
		North Carolina
		North Dakota
		Ohio
		Oklahoma
		Oregon
		Pennsylvania
		Puerto Rico
		Rhode Island
		South Carolina
		South Dakota
		Tennessee
		Texas
		Utah
		Vermont
		Virginia
		Washington
		West Virginia
		Wisconsin
		Wyoming
What is the plan's total health care spend (in- and out-of-network)?		
For the look back metrics, please specify if you are using CY 2015 data or most recent 12 months.		
If you are using most recent 12 months, please specify the 12 month period.		
Does your submission include prescription drug claims data under the pharmacy benefit in the denominator (total spend)?		Yes
		If Yes, what percent of the pharmacy benefit spend is included?
		No
Does your submission include behavioral health claims data in the denominator (total spend)?		Yes
		If Yes, what percent of the behavioral health spend is included?
		No

Questions	Responses	
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? Please report your response in hours.	Hours =	

MEDICAID ONLY: LOOKBACK METRICS
DRAFT REVISED METRICS FOR APM FRAMEWORK
4.20.16

Goal/Purpose = Track total dollars paid through legacy payments and alternative payment methods (APMs) in calendar year (CY) 2015 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 "look back" metrics (also known as retrospective metrics) should report actual dollars paid to providers through APMs CY 2015 or the most recent 12 months for which the plan has data. For example, if the plan paid a provider $120,000 for the entire year, but entered a shared savings contract with the plan on July 1, 2015, half of the payments the provider received ($60,000) would be reported as fee-for-service (Category 1) and the other half of the payments the provider received ($60,000) would be reported as shared savings (Category 3).

An acceptable but less preferable approach is annualizing dollars paid in APMs based on a point in time, e.g. on a single day such as December 31, 2015, as long as 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 2015. An unacceptable approach is counting all of dollars paid to a provider as being in APMs for the entire year, regardless of when the contract was executed (e.g. 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. 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).

Metrics

Please note that the dollars paid through the various APMs (numerator) are actual dollars paid **to providers** CY 2015 or most recent 12 months. 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

Alternative Payment Model Framework - Category 1 (Metrics below apply to total dollars paid for MA Members. Metrics are NOT linked to quality)

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
1	NA	NA	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Denominator to inform the metrics below.	NA	NA	
2	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Dollars under legacy payments (including FFS without a quality component and DRGs): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2015 or most recent 12 months.	#DIV/0!	

Alternative Payment Model Framework - Category 2 (All methods below are linked to quality).

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
3	Dollars paid for <u>foundational spending to improve care</u> (linked to quality) in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2015 or most recent 12 months.	#DIV/0!	
4	Total dollars paid to providers through <u>FFS plus P4P payments</u> (linked to quality) in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2015 or most recent 12 months. * CPR historic metric - trend.	#DIV/0!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
5	Total dollars paid in Category 2 in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Roll-up metric showing the percentage of payments in Category 2.	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 (All methods below are linked to quality)

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
6	Total dollars paid to providers through FFS-based shared-savings (linked to quality) payments in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in CY 2015 or most recent 12 months.	#DIV/0!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
7	Total dollars paid to providers through FFS-based shared-risk (linked to quality) payments in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Dollars in shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments in CY 2015 or most recent 12 months.	#DIV/0!	
8	Total dollars paid to providers through procedure-based bundled/episode payments (linked to quality) programs in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2015 or most recent 12 months.	#DIV/0!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
9	Total dollars paid to providers through population-based payments that are not condition-specific (linked to quality) in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	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 2015 or most recent 12 months.	#DIV/0!	
10	Total dollars paid in Category 3 in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Roll-up metric showing the percentage of payments in Category 3.	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.	#DIV/0!	

Alternative Payment Model Framework - Category 4 (All methods below are linked to quality)

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
11	Total dollars paid to providers through population-based payments for conditions (linked to quality) in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2015 or most recent 12 months.	#DIV/0!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
12	Total dollars paid to providers through condition-specific, bundled/episode payments (linked to quality) in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	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 2015 or most recent 12 months.	#DIV/0!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
13	Total dollars paid to providers through full or percent of premium population-based payments (linked to quality) in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Single metric displayed as a percentage (numerator divided by denominator).	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 2015 or most recent 12 months.	#DIV/0!	
14	Total dollars paid in Category 4 in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Roll-up metric showing the percentage of payments in Category 4.	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)

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
15	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Roll-up metric showing the percentage of payments that are still based on legacy payments.	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!	
16	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Roll-up metric based upon the distribution of payment reform models.	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2015 or most recent 12 months.	#DIV/0!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2015 or most recent 12 months.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2015 or most recent 12 months.	$0.00	Roll-up metric based upon the distribution of payment reform models.	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2015 or most recent 12 months.	#DIV/0!	

Attributed Consumers (Historic CPR Metric)

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
18	Total number of Medicaid, in-network health plan members attributed to a provider with a payment reform contract in CY 2015 or most recent 12 months.	[Numerator]	Number of Medicaid, in-network health plan members enrolled in CY 2015 or most recent 12 months.	[Denominator]	Single metric displayed as a percentage (numerator divided by denominator).	Payment Reform Penetration - Attributed Plan Members: Percent of Medicaid, in-network plan members attributed to a provider participating in a payment reform contract in CY 2015 or most recent 12 months.	#VALUE!	

Provider Participation

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
19	Number of providers who participate in at least one APM contract in Categories 3 and 4.	[Numerator]	Total number of providers with whom plan has contracts.	[Denominator]	Single metric displayed as a percentage.	Percent of plan's contracted providers who have at least one APM contract in Categories 3 or 4.	#VALUE!	

Benchmarks for Trend: All Cause Readmissions (Historic CPR Metric)

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data
20	Number of observed acute readmissions for any diagnosis within 30 days, for members 18 years of age and older.	[Numerator]	Total number of acute inpatient stays during the measurement year.	[Denominator]	Single metric displayed as a percentage (numerator divided by denominator).	Readmission Rate: Percent of total hospital admissions that are readmissions for any diagnosis within 30 days of discharge for members 18 years of age and older. NCQA Plan All Cause Readmissions (PCR) measure.	#VALUE!	

#	Numerator	Numerator Value	Denominator	Denominator Value	Method for Calculating & Reporting the Metric	Metric	Metric Calculation	Please list any assumptions, qualifications, considerations, or other limitations of the data

MEDICAID ONLY: CROSS-CHECKING QUESTIONS
DRAFT REVISED METRICS FOR APM FRAMEWORK
4.20.16

#	Questions		Responses
21	What payment models were in effect during specified the period of reporting?		Select all that apply:
			Foundational spending to improve care
			FFS plus Pay for Performance
			FFS-based Shared Savings
			FFS-based Shared Risk
			Procedure-based Bundled/Episode Payments
			Population-based Payments not condition-specific
			Population-based Payments condition-specific
			Condition-Specific Bundled/Episode Payments
			Full or Percent of Premium Population-based Payment
22	For each program identified in Q21, indicate when the program was launched.		Launch Date (Month/Year in Column C)
			Foundational spending to improve care
			FFS plus Pay for Performance
			FFS-based Shared Savings
			FFS-based Shared Risk
			Procedure-based Bundled/Episode Payments
			Population-based Payments not condition-specific
			Population-based Payments condition-specific
			Condition-Specific Bundled/Episode Payments
			Full or Percent of Premium Population-based Payment
23	For each program identified in Q21, describe its current stage of implementation. (Pilot, Expansion, Fully Implemented)*		Indicate Pilot, Expansion, or Fully Implemented* in Column C
			Foundational spending to improve care

#	Questions		Responses
			FFS plus Pay for Performance
			FFS-based Shared Savings
			FFS-based Shared Risk
			Procedure-based Bundled/Episode Payments
			Population-based Payments not condition-specific
			Population-based Payments condition-specific
			Condition-Specific Bundled/Episode Payments
			Full or Percent of Premium Population-based Payment

* Pilot mode (e.g. only available for a subset of members and/or providers)
Expansion mode (e.g. passed initial pilot stage)
Fully implemented (e.g. generally available)

MEDICAID ONLY: JANUARY 2016 METRICS
DRAFT REVISED METRICS FOR APM FRAMEWORK
4.20.16

Goal/Purpose = Track total dollars paid through APMs in Category 3 and 4 based on contracts in place on January 1, 2016.

This goal is NOT to gather information on a projection or estimation of where the plan expects to be on December 31, 2016. Rather, it is based on actual members and/or dollars paid based on "inked" contracts in place on 1/1/16.

Methods

We understand plans may have different methods to calculate the dollars flowing through APMs based on contracts in place on 1/1/16. Therefore, the plan is free to use a methodology that best suits their data systems and organization to the extent that it answers the question. Two examples of methodologies follow:

		NUMERATOR	DENOMINATOR
1	**Example 1**	Number of members attributed to [APM] based on contracts in place on 1/1/16 **MULTIPLIED BY:** Average cost per member per month (annualized)	Total spend as of 1/1/16 annualized
2	**Example 2**	Most recent dollars paid through [APM] payments	Most recent total spend

Key Issue To Address

Depending on the methodology used to calculate the numerators, plan must be sure that there is little to no double counting of members or dollars paid. Additional guidance is below.

		DESCRIPTION	EXAMPLE
1	**ADJUSTING FOR DOUBLE COUNTING/OVERLAP**	In some cases, the methodology used to calculate the numerator may not account for possible double counting of members or dollars. When double counting occurs, a methodology should be used to "discount" the number of members attributed to the most prominently attributed APM from the less prominently attributed APMs.	A health plan has members attributed to both an ACO (shared savings) and a bundled payment program. In this case, the plan would discount the ACO numerator from the bundled payment program by taking the percent of total dollars paid through shared savings (e.g. 20% of total health spend) and multiplying 1 - that percent (20%) by the total dollars paid through bundled payment ($700 million), which is equal to $560 million. This new numerator is then divided by the denominator above. $700 million (1 - 20%) = $560 million / [denominator]

Metrics

Please note that the dollars paid through the various APMs (numerator) are based on "inked" contracts in place on January 1, 2016. It is NOT a projection for APM spending by December 31, 2016 and does not factor in attrition or growth in membership, contracts, dollars anticipated during CY 2016.

#	NUMERATOR	NUMERATOR VALUE	DENOMINATOR	DENOMINATOR VALUE	METRIC	METRIC CALCULATION
1	NA	NA	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Denominator to inform the metrics below	0

ALTERNATIVE PAYMENT MODEL FRAMEWORK - CATEGORY 3 (APMs BUILT ON A FEE-FOR-SERVICE ARCHITECTURE)

#	NUMERATOR	NUMERATOR VALUE	DENOMINATOR	DENOMINATOR VALUE	METRIC	METRIC CALCULATION
2	Total dollars paid through FFS-based shared-savings (linked to quality) payments based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments based on contracts in place on 1/1/16.	#DIV/0!
3	Total dollars paid through FFS-based shared-risk (linked to quality) payments based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Dollars in shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments based on contracts in place on 1/1/16.	#DIV/0!

#	NUMERATOR	NUMERATOR VALUE	DENOMINATOR	DENOMINATOR VALUE	METRIC	METRIC CALCULATION
4	Total dollars paid through procedure-based bundled/episode payments (linked to quality) programs based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments based on contracts in place on 1/1/16.	#DIV/0!
5	Total dollars paid through population-based payments that are not condition-specific (linked to quality) based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$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 not condition specific based on contracts in place on 1/1/16.	#DIV/0!
6	Total dollars paid in Category 3 based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$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 (POPULATION BASED PAYMENTS THAT ARE CONDITION SPECIFIC OR COMPREHENSIVE)

#	NUMERATOR	NUMERATOR VALUE	DENOMINATOR	DENOMINATOR VALUE	METRIC	METRIC CALCULATION
7	Total dollars paid through population-based payments for conditions (linked to quality) based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality based on contracts in place on 1/1/16.	#DIV/0!
8	Total dollars paid through condition-specific, bundled/episode payments (linked to quality) based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$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 based on contracts in place on 1/1/16.	#DIV/0!

#	NUMERATOR	NUMERATOR VALUE	DENOMINATOR	DENOMINATOR VALUE	METRIC	METRIC CALCULATION
9	Total dollars paid through full or percent of premium population-based payments (linked to quality) based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$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 based on contracts in place on 1/1/16.	#DIV/0!
10	Total dollars paid in Category 4 based on contracts in place on 1/1/16.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.	#DIV/0!

AGGREGATED METRICS (CATEGORY 3 AND CATEGORY 4)

#	NUMERATOR	NUMERATOR VALUE	DENOMINATOR	DENOMINATOR VALUE	METRIC	METRIC CALCULATION
11	Total dollars paid through APMs in Categories 3 and 4 based on contracts in place on January 1, 2016.	$0.00	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries based on contracts in place on 1/1/16.	$0.00	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through APMs in Categories 3 and 4 based on contracts in place 1/1/16.	#DIV/0!

12	**Plan's target percent of spend in alternative payment methods (APMs) Categories 3 & 4 by December 31, 2016:**	0.00%

MEDICAID ONLY: DEFINITIONS
DRAFT REVISED METRICS FOR APM FRAMEWORK
4.20.16

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.
	APM Framework White Paper
	MACRA Website
Attribution	A methodology that uses patient attestation and claims/encounter data to assign a patient population to a provider group/delivery system to manage the population's health, with calculated health care costs/savings or quality of care scores for that population. For some products, an individual consumer may select a network of physicians at the point of enrollment in a health plan (e.g. HMO). The Framework is agnostic to the attribution method (e.g. prospective or concurrent).
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.
Medicaid Beneficiaries	Medicaid health plan beneficiaries 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 2015 or most recent 12 months	Calendar year 2015 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." This is not an annualized (point-in-time) reporting.
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
Double Count Adjustment (aka discounting or reductions for double counting)	When providing a point-in time January 1, 2016 payment, it is important to adjust for possible double counting of members attributed to multiple APMs. For example, it is possible that a member affiliated with a shared savings ACO is also affiliated with a bundled payment program. The reporting health plan either has to create a hierarchy where the situation for double counting members is eliminated or greatly reduced, or identify the prominent APM and adjust other programs for any overlap in members. For example, if a shared savings ACO is the most prominent model for the health plan, the health plan would discount the percent of total dollars paid through shared savings (numerator/denominator) from the total dollars paid through bundled payment. For example, if the percent of total dollars paid through shared savings is 20% and the total dollars paid through bundled payment is $500 million, one would multiply 500 million x (1-0.20) = $400 million.
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**]
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]**
As of January 1, 2016	A point in time in which health plans will report data. The metric will account for the contracts in place on that date and estimate the number of members attributed to those contracts. The contracts referenced for this metric must already be "inked" on 1/1/16. This metric does not reflect potential contracts that might be expected in CY 2016, nor does it adjust for possible growth or attrition of members, contracts, dollars.
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**].

Terms	Definitions
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."
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.
Readmissions for any diagnosis within 30 days	The number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, for members 18 years of age and older.

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) 2015 or most recent 12 months.