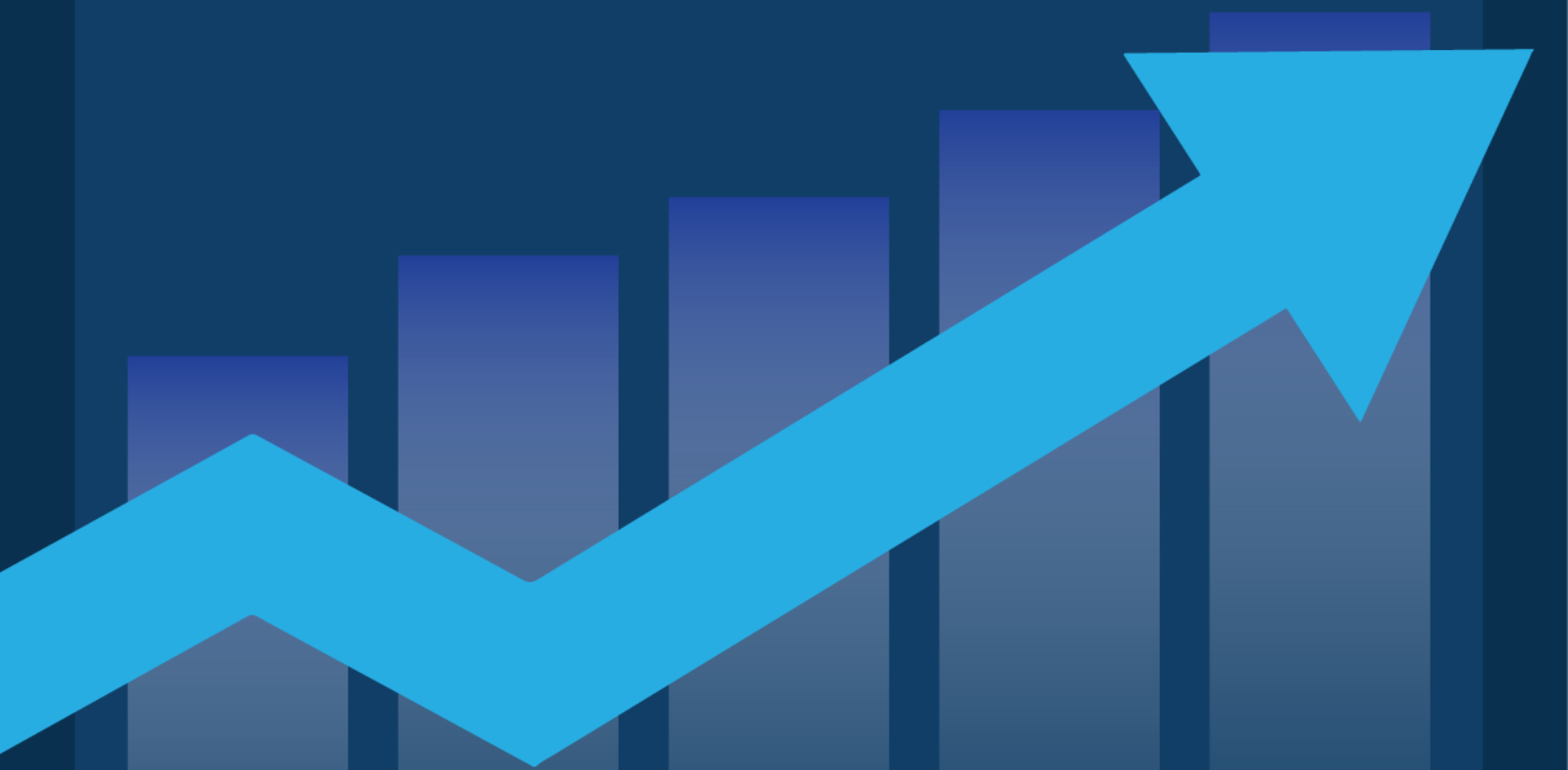
APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS



2024 Methodology and Results Report

HCPLAN

Health Care Payment Learning & Action Network

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Executive Summary

The 2024 Health Care Payment Learning & Action Network (HCPLAN) Measurement Effort launched in May 2024 and concluded at the end of July 2024. Health plans, states, and Traditional Medicare provided retrospective data on actual dollars paid to providers and total lives covered in accountable care arrangements during calendar year (CY) 2023 or the most recent 12-month period for which the data was available. A total of 73 health plans, four fee-for-service (FFS) Medicaid states, and Traditional Medicare participated in the 2024 HCPLAN Measurement Effort representing almost 282.9 million or 92.7% of people covered by an insurance plan in the commercial, Medicare Advantage, Medicaid, or Traditional Medicare lines of business (LOB).[1]

The 2024 results highlight payments made during CY 2023 for all lines of businesses. The payments were categorized based on the HCPLAN APM Framework (Figure 1). In CY 2023, 28.5% of U.S. health care payments flowed through downside risk contracts (Categories 3B-4) across all LOBs, compared to 24.5% in CY 2022.

Moreover, the data on accountable care reveals the number of lives covered under accountable care arrangements during CY 2023, for Traditional Medicare, Medicaid, and for all lines of business combined (Figure 2). 88.5 million lives from data contributors were in accountable care arrangements across all LOBs,[2] compared to 81.2 million lives in CY 2022.[3]

The HCPLAN also continues to track the barriers and facilitators to Alternative Payment Model (APM) adoption through informational questions fielded in the survey. The HCPLAN remains interested in how APMs are being used to address disparities in care. For most frequently reported strategies, Table 3: Responses to the Informational Questions.

Overview of the HCPLAN Measurement Effort

The HCPLAN measures nationwide progress toward APM adoption and accountable care to help build a more effective health care system. Eight years ago, the HCPLAN launched its first national Measurement Effort to assess the adoption of APMs in the commercial, Medicare Advantage, and Medicaid lines of business, and has subsequently tracked progress and changes over time. All previous Measurement Methodology and Results Reports are available to view on the Measurement Effort Results page on the HCPLAN website.

Annually, the HCPLAN invites health plans and other payers (e.g., state Medicaid agencies) to participate each spring with the aggregated results released in the fall. Participating organizations nationwide use common definitions of APMs, including the HCPLAN's APM Framework.

[1] The percentage of the national market is based on a denominator of approximately 305M lives covered by any health insurance plan. U.S. Census Bureau, "Health Insurance Coverage in the United States: 2023; Current Population Reports." Issued September 2024. Available at Health Insurance Coverage in the United States: 2023 (census.gov). Accessed October 4, 2024. The sources for the individual lines of business vary, and do not total the aggregate denominator. See "Limitations" section.
[2] For CY 2023, 88.5 million represents partial industry data. Data may be updated in a future release.
[3] CY 2022 covered lives information for all LOBs has been revised from the original figures issued in October 2023 based on additional analysis and data validation.

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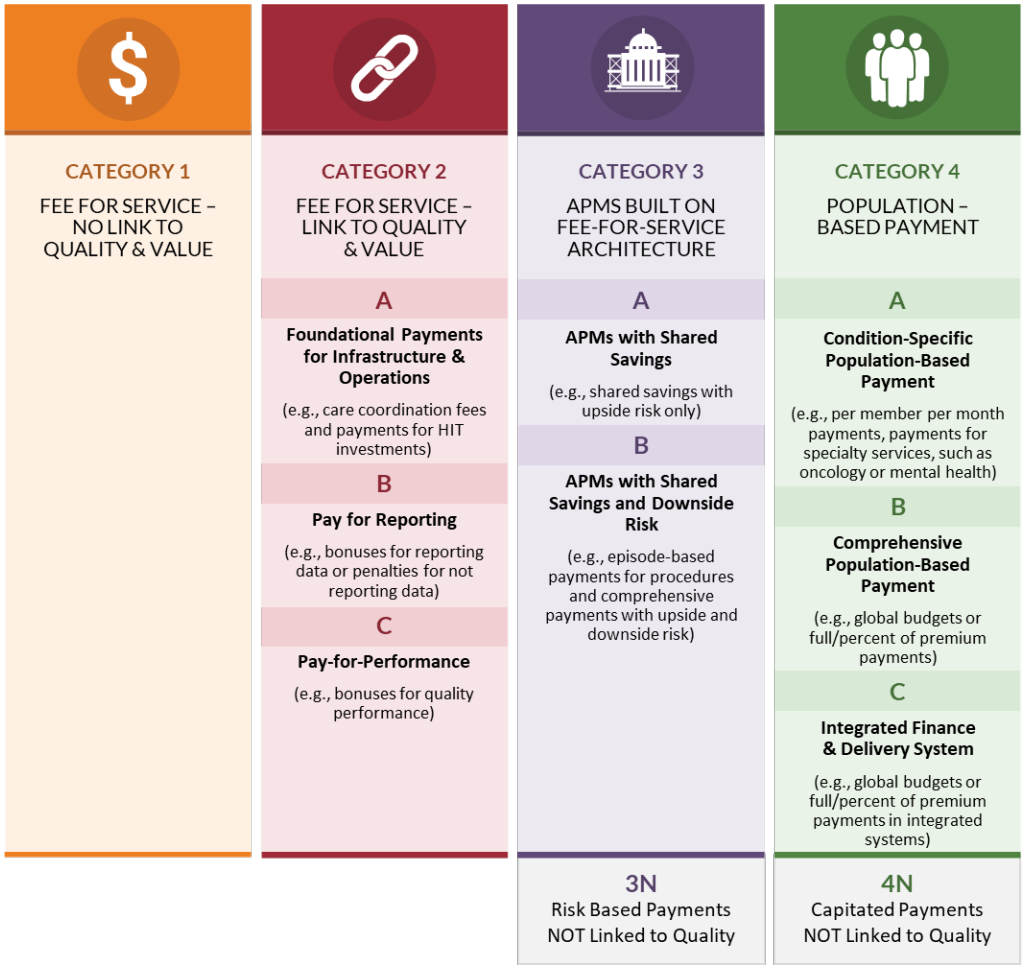
Alternative Payment Models (APMs) Overview

APMs aim to improve health care quality and lower costs by realigning payment incentives and care delivery. The HCPLAN was established to accelerate APM adoption and drive alignment in payment reform approaches across the public and private sectors. Participating plans and states categorized payments according to the HCPLAN APM Framework (Figure 1) definitions and methodology.

Figure 1: HCPLAN APM Framework



The HCPLAN has set APM goals for downside risk alternative payment models (Categories 3B and 4 of the HCPLAN APM Framework (Figure 1)) by line of business through 2030 (Figure 2). Following research and stakeholder conversations, the HCPLAN took into consideration the factors that affect the industry across the LOBs and has proposed the following APM goals through 2030. To provide near-term benchmarks in support of acceleration and achievement of these goals by 2030, the HCPLAN has determined interim APM goals for years 2024 and 2025 (see Figure 2).

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Figure 2: HCPLAN 2030 APM Goals

GOAL STATEMENT

Accelerate the percentage of U.S. health care payments tied to quality and value in each market segment through the adoption of downside risk alternative payment models (Categories 3B and 4 of the HCPLAN APM Framework (Figure 1).

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

Lives in Accountable Care Arrangements Overview

The HCPLAN defines "accountable care" as care that "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, longitudinal care." To measure and establish a baseline of lives in accountable care relationships across the lines of business, the HCPLAN developed metrics in 2022. The initial development of these metrics was informed by individual health plans and states, with refinements made in consultation with HCPLAN's survey partners: AHIP, Blue Cross Blue Shield Association (BCBSA), and the Centers for Medicare & Medicaid Services (CMS). All organizations agreed to include these questions in the future Measurement Efforts, beginning in 2023. Survey changes were communicated to participating health plans and states through training webinars and a Frequently Asked Questions resource. These metrics were piloted in the 2023 HCPLAN Measurement Effort and revised for the 2024 HCPLAN Measurement Effort.

For the purposes of measuring lives in accountable care, arrangements in Categories 3 and/or 4 qualify and two criteria must be present:

1. The accountable care arrangement is longitudinal in nature (i.e., the care is intended to last six months or longer).
2. The arrangement covers the total cost of care (TCOC).

These metrics align with the CMS Innovation Center (CMMI)'s goals to have all Medicare beneficiaries and the vast majority of Medicaid beneficiaries in an accountable relationship by 2030.[4] The HCPLAN supports greater investment in, and adoption of effective accountable care arrangements and increased number of individuals attributed to accountable care relationships across all lines of business from CY 2022 to CY 2023.

[4] In October 2021, CMMI issued a strategy refresh document, which outlined the Innovation Center's strategy for its second decade. This white paper stated that the Innovation Center's first strategic objective was to drive accountable care. In November 2022, CMMI released a document on the implementation of its strategy. This document conveys a roadmap for Innovation Center models and initiatives, including metrics, baselines, and targets for meeting the strategic objectives.

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2024 HCPLAN Measurement Effort Methodology

The 2024 HCPLAN Measurement Effort, conducted from May to July 2024, collected retrospective data from health plans, states, and Traditional Medicare on payments made to providers and the number of lives covered under accountable care arrangements during CY 2023. Data was sourced through surveys fielded by AHIP, BCBSA, and the HCPLAN, with CMS providing Traditional Medicare data directly. The collected data was categorized according to the HCPLAN APM Framework (Figure 1), and analyzed for consistency and accuracy by the HCPLAN Operator, ensuring confidentiality and integrity. The methodology also included tracking barriers and facilitators to APM adoption. The aggregated data provided insights into the adoption of APMs and the extent of accountable care arrangements across different lines of business.

Data Sources

The HCPLAN continued to collaborate with AHIP and BCBSA, requesting and aggregating data from health plans. AHIP and BCBSA fielded surveys to their member health plans. They identified health plans that are members of both associations and coordinated to ensure there were no duplicate responses in their respective data sets. The HCPLAN fields an online survey to health plans who do not belong to either AHIP or BCBSA and to Medicaid FFS states (see The HCPLAN Survey section), CMS contributes Traditional Medicare data using its internal data sources and does not field a survey.

The data collected through the AHIP, BCBSA, and HCPLAN surveys, as well as the data reported by CMS, is described in Table 1 and Table 2 and Appendix A's Table 1 and Table 2.

The HCPLAN Survey

The 2024 HCPLAN data collection period for capturing CY 2023 data started on May 20, 2024, and concluded on July 31, 2024. Individual health plan and state data were kept confidential. To maintain impartiality and participant confidentiality, the HCPLAN Operator[5] – not the United States Department of Health and Human Services (HHS) – received, analyzed, and aggregated all individual plan and state data.

The HCPLAN Operator examined health plan responses to detect any outliers or inconsistencies and posed follow-up questions to ensure data integrity. Health plans and states either clarified or modified their responses as appropriate.

In addition to the data collected, the HCPLAN survey gave organizations the option to be recognized for their data contributions, while maintaining the confidentiality of their individual data.

The AHIP Survey

The 2024 survey was fielded by AHIP and administered through Qualtrics software (Qualtrics, Provo, UT). Questions focused on the dollars associated with APMs, as defined using the refreshed HCPLAN APM Framework (Figure 1). In addition, questions focused on counting the number of lives in accountable care arrangements in Categories 3 and 4 were included. AHIP recruited its member health plans through email and phone outreach. Using a key informant approach, AHIP initially

[5] The HCPLAN is operated by Deloitte Consulting LLP, with the LAN Operator work funded by the Centers for Medicare & Medicaid Services under contract number 75FCMC19D0085/75FCMC21F0001.

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emailed survey invitations to respondents from the prior year. If the designee was no longer with the organization or unresponsive, follow-up was undertaken with chief medical officers, provider contracting leads, and payment innovation staff from their member plans, who then shared the survey with their teams, as appropriate. AHIP member plans responded directly to AHIP, and only aggregate data was shared with the HCPLAN.

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

The Blue Cross Blue Shield Association (BCBSA) Survey

To collect the required data points, BCBSA included questions in an annual survey of member plans addressing the delivery of value-based health care and assessing the number of lives in accountable care arrangements in Categories 3 and 4. BCBSA collaborated with the HCPLAN and AHIP to ensure alignment of survey questions to facilitate data aggregation.

BCBSA reported the data elements described in the Tables and those listed below, in aggregate to the HCPLAN for the purposes of measuring multiple payers' adoption of APMs nationally:

- Total number of participating plans
- Total number of lives in accountable care arrangements by participating plans

Data was collected for health care spending paid to all providers for dates of service in CY 2023 (January 1 to December 31) or the most recent 12-month period, and the covered lives data point was requested for the same period (January 1 to December 31). The data elements listed above reflect 2023 data and were submitted to, validated by, and aggregated by BCBSA.

Traditional Medicare

CMS reported Traditional Medicare spending in CY 2023 to the HCPLAN. CMS also collaborated with AHIP, BCBSA, and the HCPLAN to align methodologies and facilitate data aggregation for reporting national progress. The CY 2023 Medicare Parts A and B data included the total dollars paid to providers participating in Traditional Medicare APMs in CY 2023 by category and subcategory and the total number of Traditional Medicare covered in accountable care arrangements.

The Traditional Medicare results are considered interim because they are based on only three quarters of CY 2023 actual claims data. Due to claims run-out and data lag issues, each quarter of actual claims data becomes available seven to eight months after the end of the quarter.

The APMs CMS used to calculate the percent of payments made through Categories 3 and 4 of the HCPLAN APM Framework (Figure 1) in CY 2023 include shared savings, shared risk, and population-based payment models. Payment calculations include consideration of model overlap when it may be possible for beneficiaries to be enrolled in multiple models. The most recent 2023 CMS Office of the Actuary (OACT) annual total expenditures in Traditional Medicare data is used to calculate the denominator and is obtained directly from OACT.

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Merging the Data

The HCPLAN merged the data elements from the AHIP and BCBSA surveys, Traditional Medicare, along with health plans and states that submitted directly to the HCPLAN. The data elements that were merged included the dollars associated with APMs and the number of lives in accountable care arrangements. A description of each entities' data elements is described below.

Data Elements

The HCPLAN Measurement Effort collects both quantitative and qualitative data related to APMs and lives in accountable care arrangements based on the previous calendar year or the most recent 12 months. Quantitative data focuses on the financial expenditures of health plans and FFS Medicaid states through APMs, categorized by the HCPLAN APM Framework (Figure 1). To measure lives in accountable care arrangements in Categories 3 and 4, the arrangements must be longitudinal and cover the total cost of care (TCOC). Additionally, surveys from HCPLAN, AHIP, and BCBSA gather insights on APM activity across health plans and payers.

APM Quantitative Data

The quantitative data collected through the HCPLAN Measurement Effort includes metrics based on the financial expenditures of health plans and FFS Medicaid states. The HCPLAN invites these entities to quantify their in- and out-of-network spending through APMs, including key areas such as pharmacy and behavioral health spending, if data is available. Participants report the dollars paid in the previous calendar year or the most recent 12 months for which they have data.

To calculate the APM metrics, health plans and states retrospectively examine the actual payments made to providers during the respective calendar year (or the most recent 12 months for which they have data) and categorize these payments according to the HCPLAN APM Framework (Figure 1). For APMs in Categories 3 and 4, which often hold providers accountable for their patients' total cost of care, health plans can report dollars paid based on members attributed to the method.

Since most payment innovations typically incorporate multiple payment methods (e.g., FFS plus a care coordination fee and shared savings), plans and states are asked to report dollars paid according to the most dominant or advanced payment method they used (e.g., shared savings or condition-specific population-based payments).

For a more detailed description of the total payment calculations in each category, see Table 1 below.

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Table 1: 2024 APM Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2023 or most recent 12 months.	*Denominator to inform the metrics below.*
CATEGORY 1 (METRICS ARE NOT LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
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.	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.
CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2023 or most recent 12 months. (Subcategory 2A)	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2023 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-reporting** payments (linked to quality) in CY 2023 or most recent 12 months. (Subcategory 2B)	Dollars in pay-for-reporting programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2023 or most recent 12 months.
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. (Subcategory 2C)	Dollars in pay-for-performance programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2023 or most recent 12 months.
Total dollars paid in **Category 2** in CY 2023 or most recent 12 months.	Payment Reform – APMs built on fee-for-service linked to quality: Percent of total dollars paid in Category 2.

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CATEGORY 3 (ALL METRICS ARE LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2023 or most recent 12 months. (Subcategory 3A)	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.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2023 or most recent 12 months. (Subcategory 3A)	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.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2023 or most recent 12 months. (Subcategory 3B)	Dollars in fee-for-service-based shared-risk programs: Percent of total dollars paid through fee-for-service-based shared-risk (linked to quality) payments in CY 2023 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2023 or most recent 12 months. (Subcategory 3B)	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.
Total dollars paid in **Category 3** in CY 2023 or most recent 12 months.	Payment Reform – APMs built on fee-for-service architecture: Percent of total dollars paid in Category 3.

CATEGORY 4 (ALL METRICS ARE LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2023 or most recent 12 months. (Subcategory 4A)	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.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2023 or most recent 12 months. (Subcategory 4A)	Dollars in condition-specific, bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode payments (linked to quality) in CY 2023 or most recent 12 months.

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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. (Subcategory 4B)	Population-based payments that are not condition-specific (linked to quality): Percent of total dollars paid through population-based payments that are not condition-specific (linked to quality) in CY 2023 or most recent 12 months.
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. (Subcategory 4B)	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments (linked to quality) in CY 2023 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery system programs** (linked to quality) in CY 2023 or most recent 12 months. (Subcategory 4C)	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs (linked to quality) in CY 2023 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2023 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

Lives in Accountable Care Arrangements Quantitative Data

To measure lives in accountable care arrangements in Categories 3 and/or 4, two criteria must be met:

1. The accountable care arrangement is longitudinal in nature (i.e., the care is intended to last six months or longer)
2. The arrangement covers the total cost of care (TCOC)

Participants are asked to provide the total number of health plan members who are attributed, aligned, assigned, or empaneled to a primary care provider (PCP) or primary care group (PCG) participating in a TCOC Category 3 or 4 APM. If health plans attribute, align, assign, or empanel members to a non-PCP or non-PCG (e.g., a specialist), they are asked to provide the total number of members attributed, aligned, assigned, or empaneled to a non-PCP or non-PCG.

To avoid double-counting members who might be attributed to both a PCP and a non-PCP, health plans can only select one method (i.e., PCP-PCG or non-PCP-non-PCG). For reporting purposes, the HCPLAN combines both the PCP-PCG plan members and the non-PCP-non-PCG plan members.

Still, survey respondents indicate that collection and reporting of covered lives comes with complexities because patients can be treated by physicians and specialists covered by multiple contractual arrangements. The HCPLAN will continue to work with respondents to understand these complexities and refine our metrics accordingly.

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See Table 2 for the specific numerator and denominator. In addition to the metrics, participants are also directed to additional guidance, including definitions and inclusion and exclusion criteria.

Table 2: 2024 Lives in Accountable Care Arrangements Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total number of health plan members in CY 2023 or most recent 12 months reported by survey respondents.	*Denominator to inform the metrics below.*

LIVES IN ACCOUNTABLE CARE ARRANGEMENTS (CATEGORIES 3-4)	
NUMERATOR	**DESCRIPTION OF METRIC**
Total number of health plan members attributed/aligned/assigned/empaneled to a primary care provider (PCP)/primary care group (PCG) or non-PCP (i.e., specialist) participating in a total cost of care **Category 3 or 4** accountable care APM in CY 2023 or most recent 12 months.	Percent of plan members attributed/aligned/assigned/empaneled to a PCP/PCG or non-PCP (i.e., specialist) participating in a total cost of care **Category 3 or 4** accountable care APM of six months or longer in CY 2023 or most recent 12 months.

Informational Qualitative Questions

The informational questions summarize responses combined from the HCPLAN, AHIP, and BCBSA surveys. The purpose was to gather opinions on APM activity and strategies across health plans and payers. See Appendix A for the specific questions and response options.

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2024 HCPLAN Measurement Effort Results

In the 2024 Measurement Effort, a total of 73 health plans, four FFS Medicaid states, and Traditional Medicare participated, representing almost 282.9 million or 92.7% of people covered by an insurance plan in the commercial, Medicare Advantage, Medicaid, or Traditional Medicare LOBs in CY 2023. The percentage of the national market is based on a denominator of approximately 305 million lives covered by any health insurance plan.[6]

Health plans, states, and Traditional Medicare reported the total dollars paid to providers through the payment methods within the subcategories according to the HCPLAN APM Framework (Figure 1). With this data, the HCPLAN calculated aggregate results for CY 2023 by line of business and at the payment method level by category and subcategory.

Beginning with the 2023 Measurement Effort, the HCPLAN fielded metrics aimed at measuring lives in accountable care arrangements and reported on these metrics for all lines of business combined and for Traditional Medicare. The 2024 Measurement Effort marks the second year of collecting lives in accountable care arrangements, and the first year reporting Medicaid data separately. Data this year will be reported for Traditional Medicare, Medicaid, and all lines of business combined.

Finally, all surveys included informational questions about the future of APM adoption. This granular data provides actionable insights into the state of APMs, enriching the quantitative results with qualitative insights that identify potential future trends.

Payments Made in CY 2023

The results are shown both overall and by line of business (commercial, Medicaid, Medicare Advantage, and Traditional Medicare) in the sections below, in alignment with the HCPLAN APM Framework (Figure 1).

[6] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2023; Current Population Reports." Issued September 2024. Available at https://www2.census.gov/library/publications/2024/demo/p60-284.pdf. Accessed October 4, 2024.

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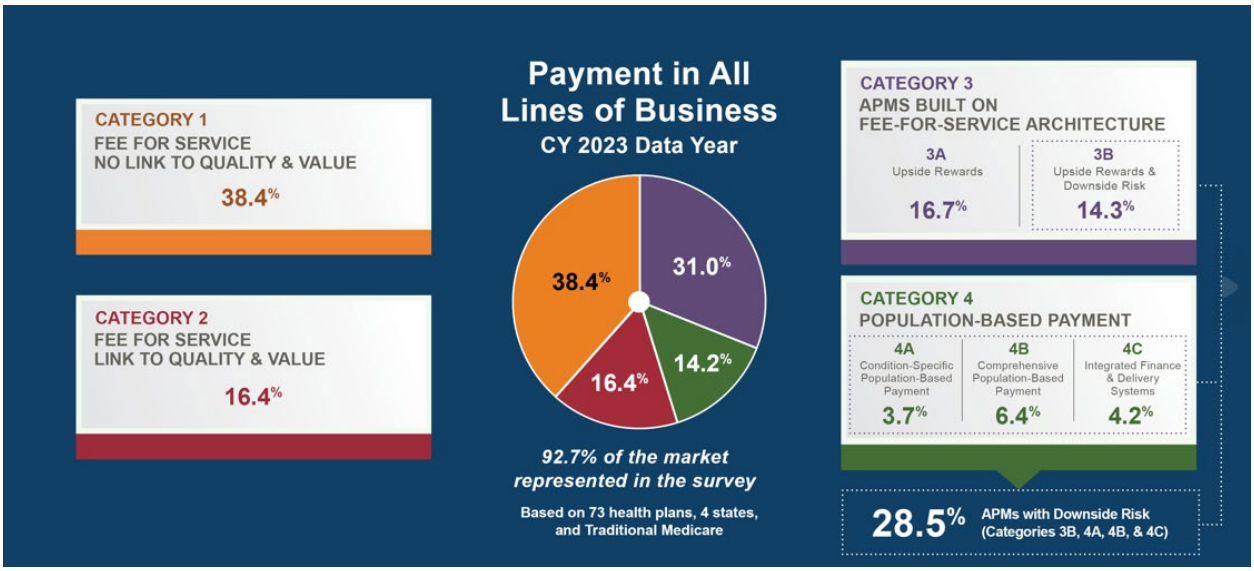
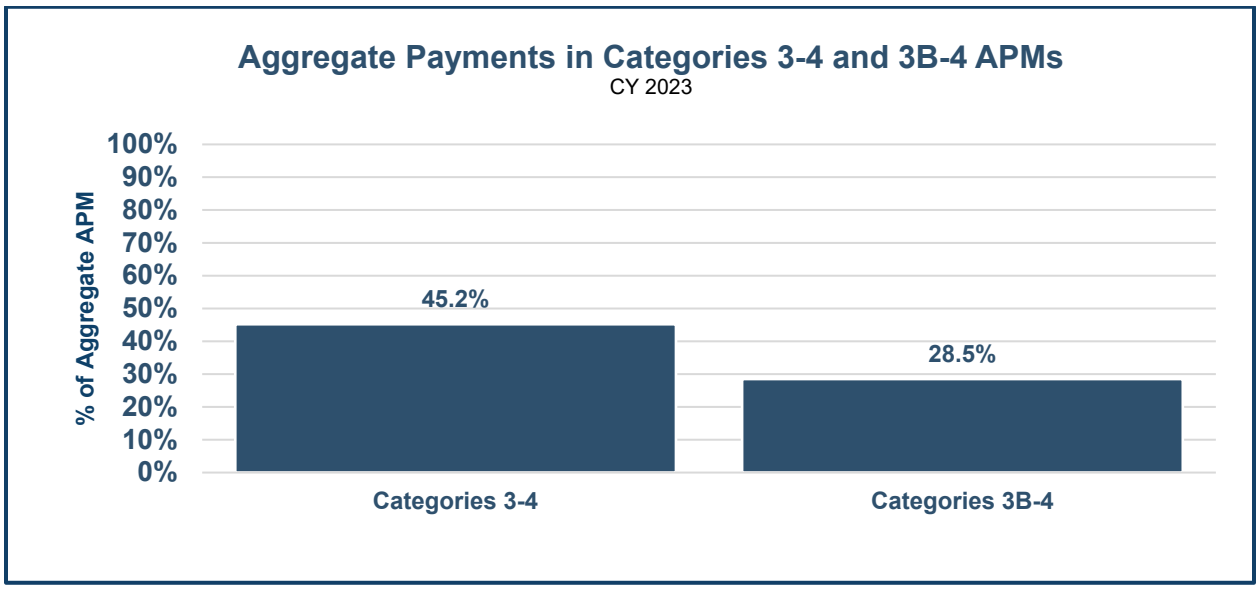
Aggregate – All lines of business of respondents reporting at the subcategory level

The combined HCPLAN, BCBSA, AHIP, and Traditional Medicare data, representing 92.7% of the national market in CY 2023[7] shows the following category and subcategory level payments made to providers in CY 2023 in all lines of business. In CY 2023, 28.5% of payments flowed through APMs categorized as 3B and above, compared to 24.5% in CY 2022.





[7] 73 health plans, 4 states, Traditional Medicare in CY 2023.

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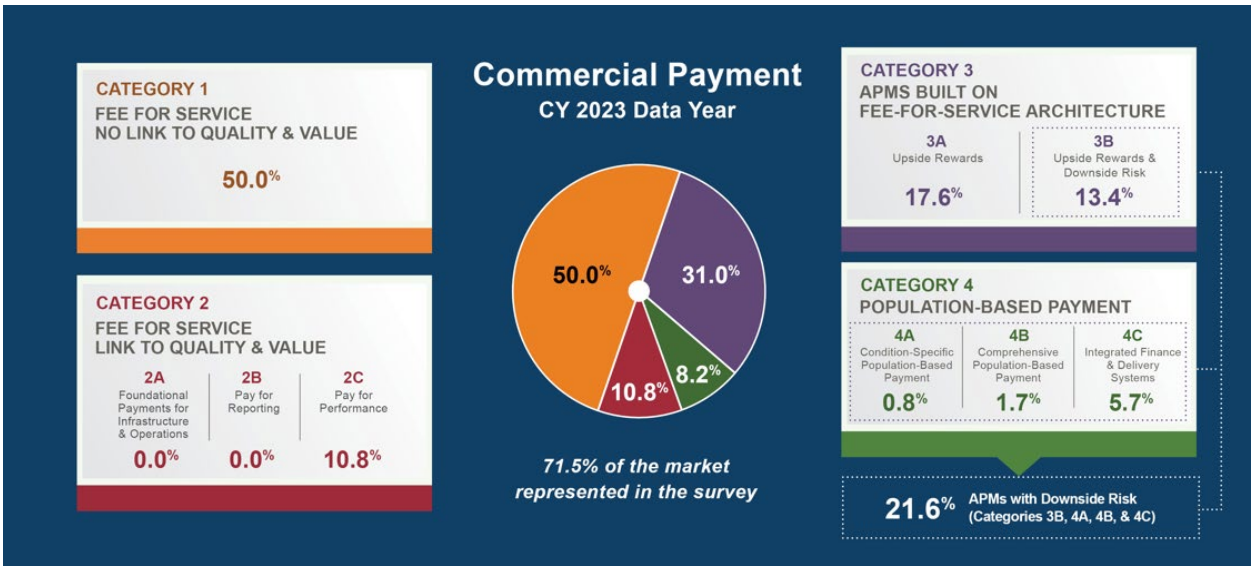
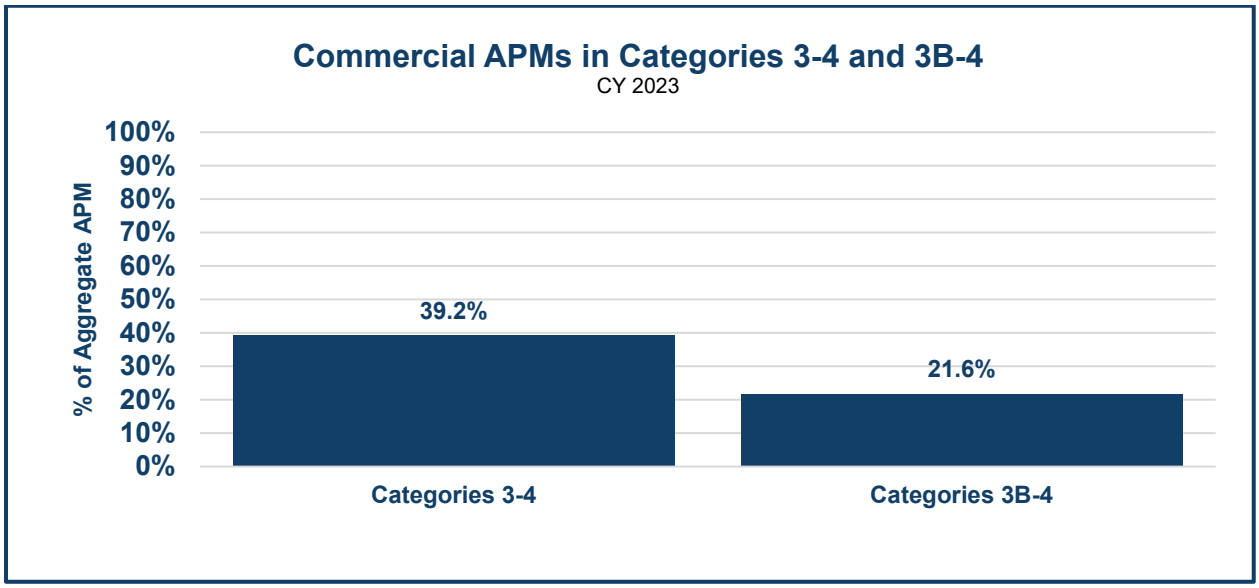
Commercial

The commercial data, representing 71.5% of the national market in CY 2023,[8] shows the following for payments made to providers in CY 2023. In CY 2023, 21.6% of payments flowed through APMs categorized as 3B and above, compared to 16.5% in CY 2022.





[8] See footnote 4.

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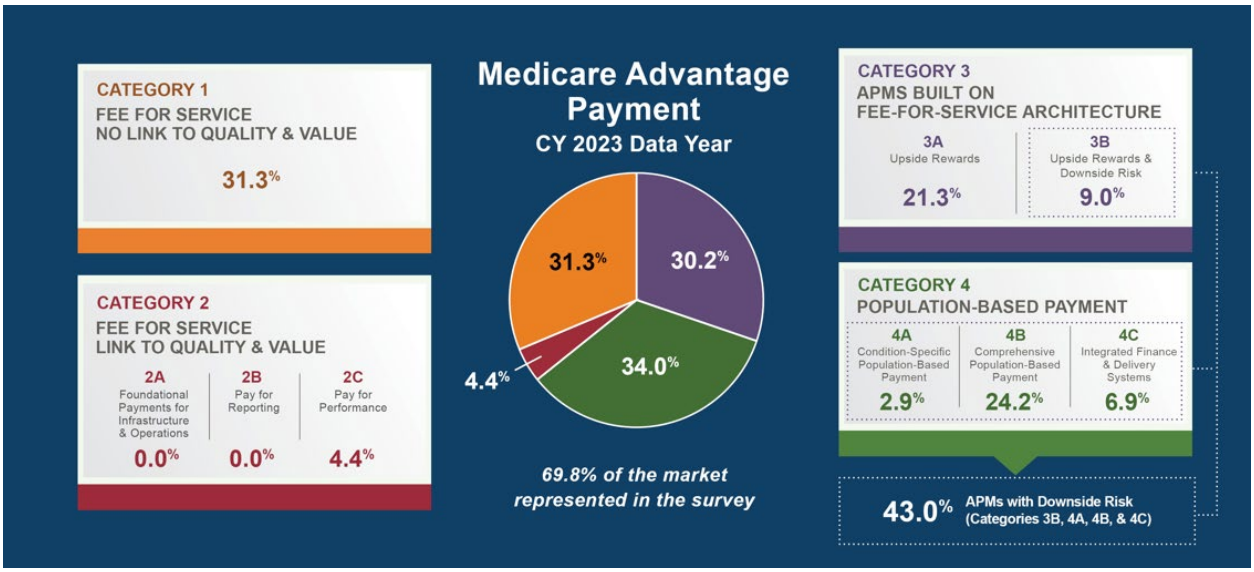
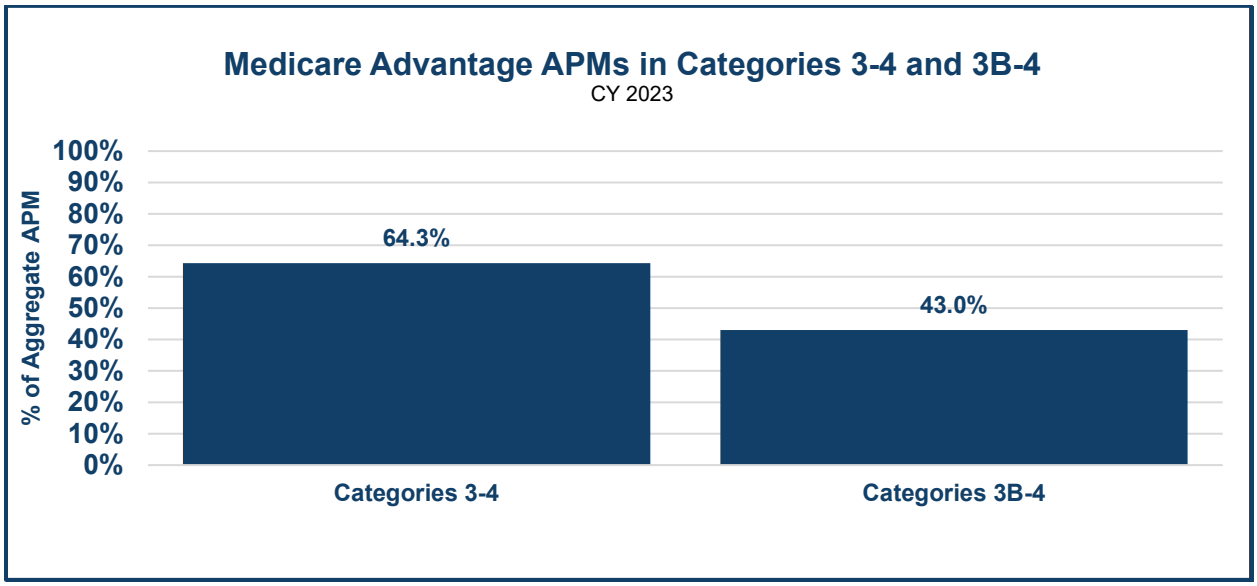
Medicare Advantage

The Medicare Advantage data, representing 69.8% of the national Medicare Advantage market *including* enrollees who are dually eligible for Medicare and Medicaid coverage in CY 2023,[9] shows the following for payments made to providers in CY 2023. In CY 2023, 43.0% of payments flowed through APMs categorized as 3B and above, compared to 38.9% in CY 2022.





[9] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," March 2024. Available at CMS Fast Facts Accessed October 4, 2024. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," September 2023. Available at MMCO Statistical & Analytic Reports | CMS. Accessed October 4, 2024.

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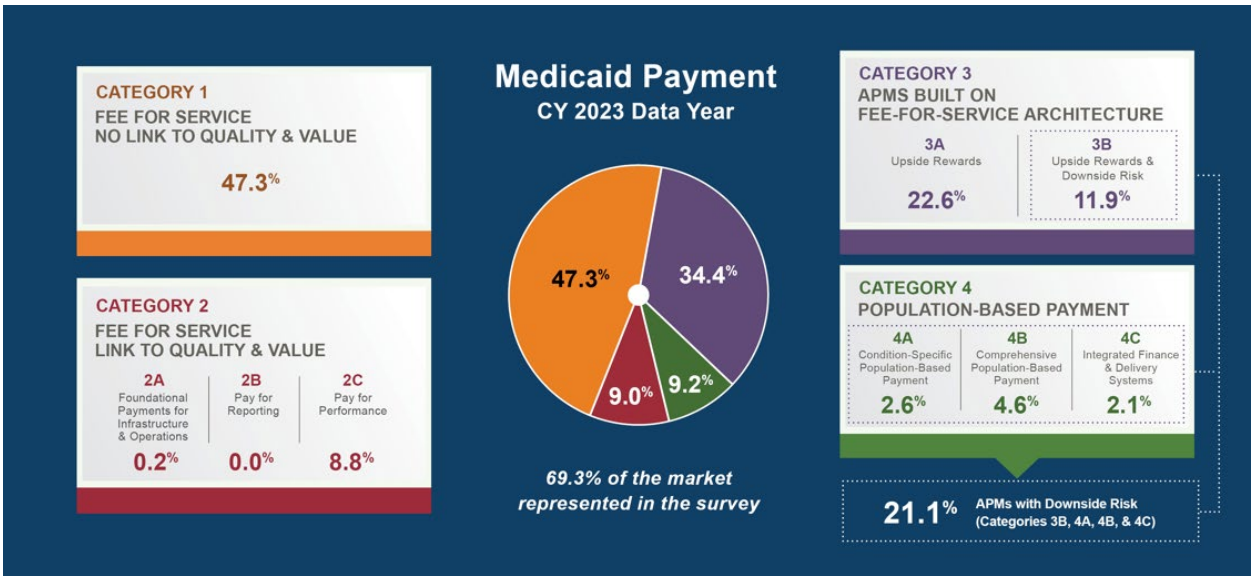
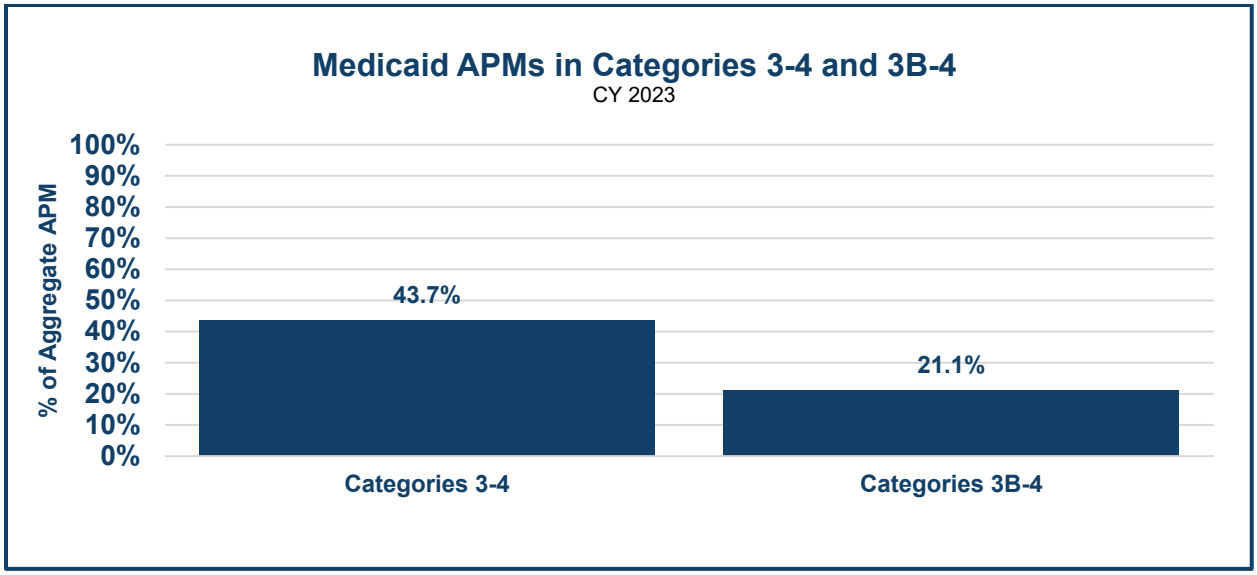
Medicaid

The Medicaid data, representing 69.3% of the national Medicaid market (*excluding* enrollees who are dually eligible for Medicare and Medicaid coverage) in CY 2023[10] shows the following for payments made to providers in CY 2023. In CY 2023, 21.1% of payments flowed through APMs categorized as 3B and above, compared to 18.7% in CY 2022.





[10] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," March 2024. Available at CMS Fast Facts. Accessed October 4, 2024.

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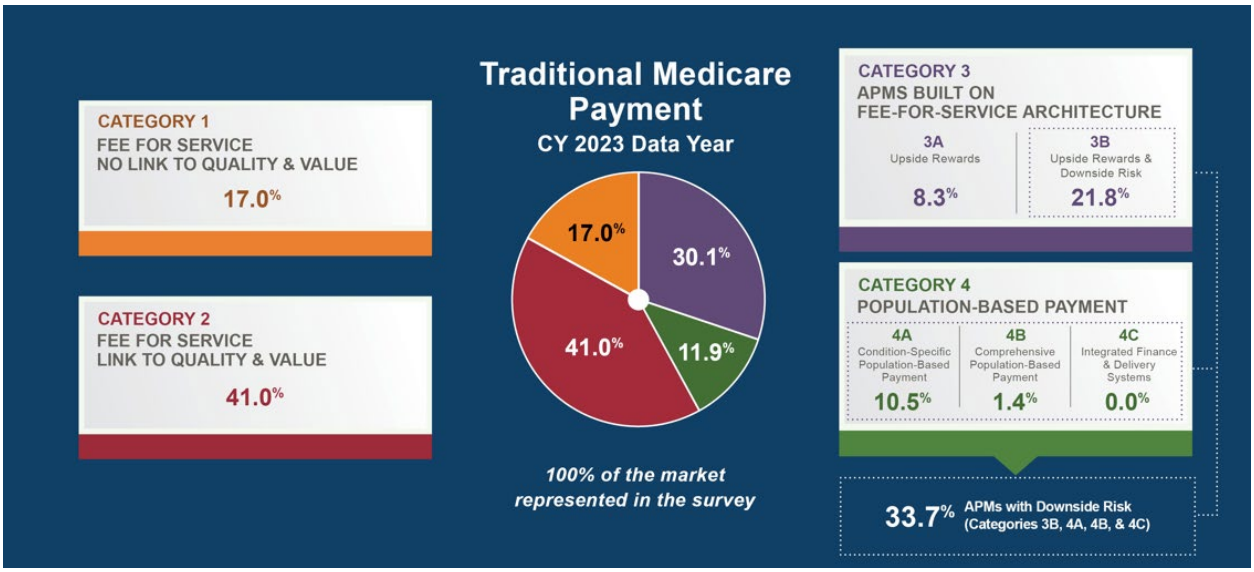
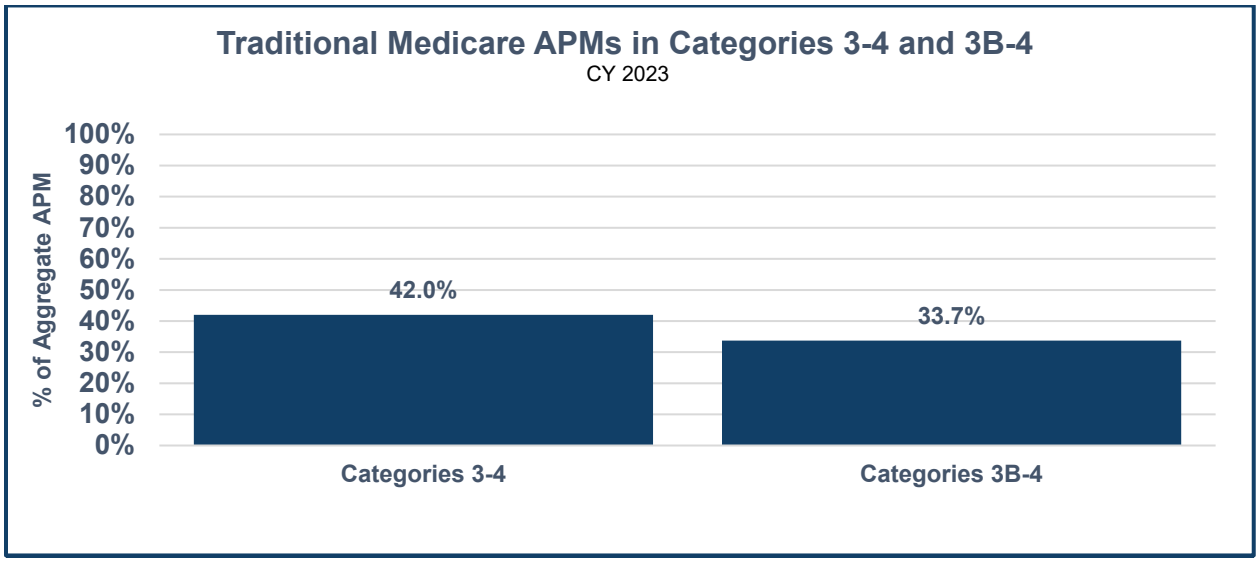
Traditional Medicare

The Traditional Medicare data, representing 34.2M Traditional Medicare beneficiaries with Parts A and/or B benefits, which is 100% of the Traditional Medicare market,[11,12] shows the following for payments made to providers in CY 2023. In CY 2023, 33.7% of payments flowed through APMs categorized as 3B and above, compared to 30.2% in CY 2022.





[11] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," March 2024. Available at CMS Fast Facts. Accessed October 4, 2024.
[12] Enhancing Oncology Model expenditure data was excluded from the 2023 APM analysis but will be included in the 2024 APM data analysis.

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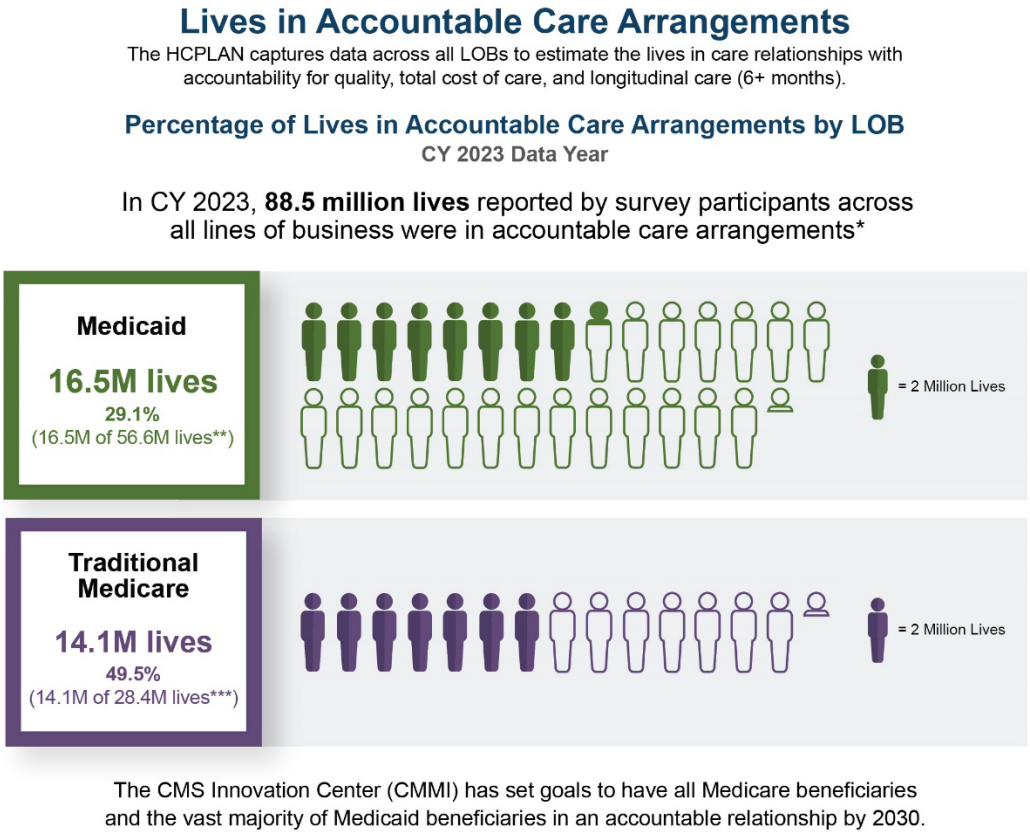
Lives in Accountable Care Arrangements in CY 2023

The combined data from the HCPLAN, BCBSA, AHIP, and Traditional Medicare shows the number of member lives in accountable care arrangements in CY 2023. In CY 2023, 88.5 million lives represented by data contributors were covered in accountable care arrangements in all LOB.[13,14] See Figure 5. Arrangements in Categories 3 and/or 4 are considered accountable care arrangements if they meet two criteria:

1. The accountable care arrangement is longitudinal in nature (i.e., the care is intended to last six months or longer)
2. The arrangement covers the total cost of care (TCOC)

Figure 5: Lives in Accountable Care Arrangements in CY 2023



[13] Represents partial industry data, and thus caution should be used when comparing year over year due to potential underreporting in CY 2023 data.
[14] Represents 100% of eligible market; partial benefit members were excluded from this analysis.

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Informational Questions

The informational questions below summarize responses combined from the HCPLAN, AHIP, and BCBSA surveys. They aimed to gather opinions on APM activity.

Table 3: Payers' Perspective Informational Questions

Payers' Perspective Informational Questions	
Payers who think APM activity:	
Will Increase	76%
Will Stay the Same	21%
Will Decrease	0%
Payers Who Are Not Sure/Declined to Respond	3%
Payers Stating that the APM Subcategory That Will Increase the Most Will Be:	
Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	59%
Traditional shared-savings, Utilization-based shared-savings (3A)	22%
Top Three Barriers to APM Adoption as Identified by Payers	
1. Provider ability to operationalize 2. Interoperability 3. Provider interest/readiness	
Top Three Facilitators to APM Adoption as Identified by Payers	
1. Provider interest/readiness 2. Health plan interest/readiness 3. Government influence	

Payers who agree or strongly agree with and payers who disagree or strongly disagree with the following: [15]	**Agree/ Strongly Agree**	**Disagree/ Strongly Disagree**
APM adoption will result in better quality of care	96%	4%
APM adoption will result in more affordable care	88%	5%
APM adoption will result in improved care coordination	94%	3%

[15] The percentages for each outcome do not add up to 100% because the "not sure" and "blank/did not answer" responses were removed from the data reported here.

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Payers' Perspective Informational Questions		
APM adoption will result in more consolidation among health care providers	31%	24%
APM adoption will result in higher unit prices for discrete services	7%	57%

Limitations

Health Plan and State Participation Is Voluntary: The Measurement Effort is voluntary and did not have full participation from all eligible health plans and states, nor did it capture 100% of the lives covered by health insurance. As a result, the findings may be biased by self-selection. Health plans and states actively pursuing payment reform may have been more likely to respond to the surveys that measure APM adoption.

Different Data Sources for Denominators for each LOB: The HCPLAN uses various sources, such as the U.S. Census Bureau and CMS Fast Facts, for the denominator to calculate the representativeness for each LOB. There is no single source that encompasses all lines of business, and each source has different methodologies and limitations. Most notably, the aggregate all LOBs denominator, the HCPLAN currently uses the U.S. Census Bureau.[16] Using the U.S. Census Bureau source is consistent with the HCPLAN's regular practice; however, combining the denominators from other sources can result in different total representativeness of the data.

Potential Variation in the Interpretation of the APM and Accountable Care Metrics: The HCPLAN worked to facilitate a consistent interpretation of the APM categories, subcategories, and accountable care metrics, including terms, as well as the methods for reporting through precise definitions, training sessions, written instructions, and discussions with individual health plans and states seeking clarification. However, the varying interpretation of the metrics could still create variability across data from individual health plans and states.

Data System Challenges: Some health plans and states reported data system challenges with reporting payment dollars according to the HCPLAN APM Framework (Figure 1) and according to the metrics counting lives in accountable care, because developing new system queries and sorting data according to the APM categories and subcategories can be cumbersome. Such data system limitations can also result in health plans reporting data from an earlier 12-month period than CY 2023, which could reflect lower levels of APM adoption.

[16] "Health Insurance Coverage in the United States: 2023; Current Population Reports," "Issued September 2024. Available at https://www2.census.gov/library/publications/2024/demo/p60-284.pdf. "Any Health Plan" in Table 1.

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For further information, please contact the HCPLAN Operator at hcplan@deloitte.com.

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Appendix A: 2024 Measurement Effort Informational Questions

Appendix A Table 1: Informational Questions

QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, what do you think will be the trend in APMs over the next 24 months?	• APM activity will increase • APM activity will stay the same • APM activity will decrease • Not sure
[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-saving (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 programs (4C) • Not sure
[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-saving (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 programs (4C) • Not sure

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QUESTIONS	RESPONSE OPTIONS
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 or disagree that APM adoption will result in each of the following outcomes:	• Better quality of 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)

Coronavirus disease 2019 (COVID-19) exposed and exacerbated underlying disparities in the health care system, which increased the importance of addressing them. The HCPLAN continues to be interested in how APMs are being used to address disparities in care. To reflect this effort, the HCPLAN fielded the same informational questions that were updated in 2021.

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Appendix B: Definitions

The following terms and definitions were developed to provide consistent guidance for survey respondents. Some of the definitions are generally accepted, and others are specific only to the HCPLAN and this Measurement Effort.

Appendix B Table 1: 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 HCPLAN'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

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TERMS	DEFINITIONS
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, and 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. See General Guidance information in the Measuring Covered Lives in Accountable Care Guidance document.
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.

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TERMS	DEFINITIONS
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, or 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	APMs built on FFS 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 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.

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TERMS	DEFINITIONS
Category 4	Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.
Commercial Line of Business	The commercial market segment includes individual, small group, large group, fully insured, self-funded, and exchange business. To the extent a health plan provides benefits for the Federal Employee Health Benefit (FEHB) program, state active employee programs, and/or an exchange, this business is considered commercial and included in the survey. Survey data reflects dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2023 or the most recent 12-month period for which data is available. Spending for dental and vision services is excluded.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants.
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g., diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A**]

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TERMS	DEFINITIONS
Condition-specific population-based payment	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. [APM Framework Category **4A**]
CY 2023 or most recent 12 months	Calendar year (CY) 2023 or the most current 12-month period for which the health plan can report payment information. This is the reporting period for which the health plan should report all of its "actual" spend data—a retrospective "look-back."
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients who 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.
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 are 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
Fee-for-service (FFS)	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes, or efficiency. [APM Framework Category **1**]

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TERMS	DEFINITIONS
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 programs	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.

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TERMS	DEFINITIONS
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. For additional explanations and examples see the Guidance for Measuring Covered Lives in Accountable Care APM Arrangements document
Medicaid Line of Business	The Medicaid market segment includes both business with a state to provide health benefits to Medicaid-eligible individuals and state-run programs themselves. Data submitted for this survey excludes the following: health care spending for dual eligible beneficiaries, health care spending for long-term services and supports (LTSS), and spending for dental and vision services. Survey data 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.
Medicare Advantage Line of Business	The Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it included this information in its response. Survey data reflect dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2023 or the most recent 12-month period for which data is available. Dental and vision services are excluded.
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**]

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TERMS	DEFINITIONS
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 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 the APM Measurement Effort, provider includes all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible, and excludes dental and vision.
Shared-risk	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. [APM Framework Category **3B**]

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TERMS	DEFINITIONS
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.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g., annual payment amount) made to providers in CY 2023 or the most recent 12 months for which data is available.
Traditional shared-savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a pre-established set target for spending, as long as they meet quality targets. Traditional shared-savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. [APM Category Framework **3A**]
Utilization-based shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g., Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead, there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to, emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets. [APM Category Framework **3A**]

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Appendix C: About the Health Care Payment Learning and Action Network Operator

The HCPLAN is operated by Deloitte Consulting LLP, with the HCPLAN Operator work funded by the Centers for Medicare & Medicaid Services (CMS) under contract number 75FCMC19D0085/75FCMC21F0001. The Health Care Payment Learning and Action Network accelerates innovation by connecting people and data to reinvent health systems, enhance the care experience, and protect and promote health and well-being. Sponsored by CMS on behalf of Department of Health and Human Services (HHS), the HCPLAN Operator serves as an objective advisor to all HHS organizations and other federal agencies with health and human services missions. The HCPLAN Operator mobilizes experts and convenes stakeholders to pioneer together for the public good, bringing innovative ideas into existence to improve the health and well-being of the nation.

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