APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS

2022 Methodology and Results Report

HCPLAN

Health Care Payment Learning & Action Network

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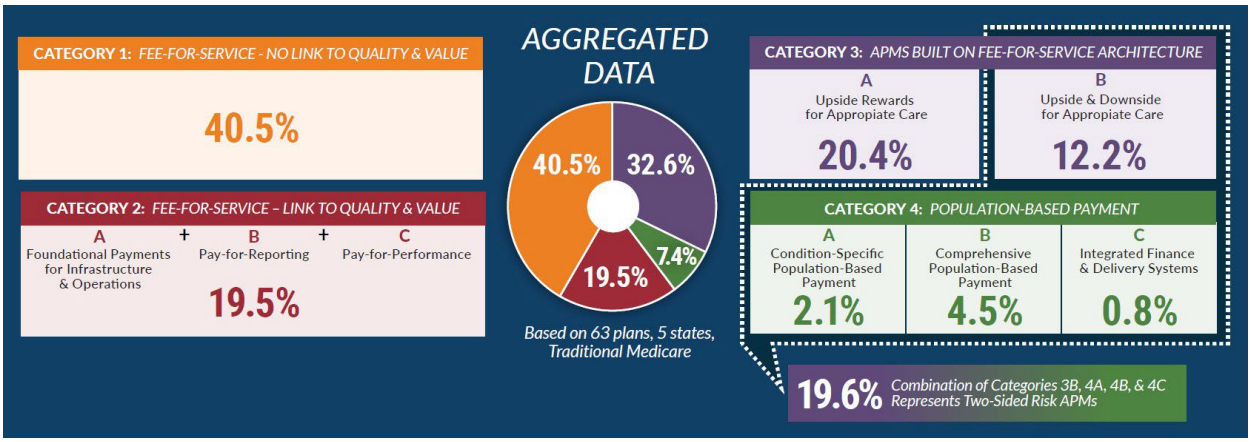
Executive Summary

The 2022 Health Care Payment Learning & Action Network (LAN) Measurement Effort data collection survey launched on May 23, 2022 and concluded on July 30, 2022. Health plans and states provided retrospective data on actual dollars paid to providers during the previous calendar year (CY) or the most recent 12-month period for which the data was available. A total of 63 health plans, five fee-for-service (FFS) Medicaid states, and Traditional Medicare participated in the 2022 LAN Measurement Effort. These health plans and states represented approximately 233,870,081 of the nation's covered lives and 77.7% of the national market. The percentage of the national market is based on a denominator of approximately 300,887,000 lives covered by any health insurance plan.[1]

The 2022 Alternative Payment Model (APM) results demonstrated the following for payments made during CY 2021 for all lines of businesses combined. The payments were categorized based on the LAN APM Framework.

Aggregated APM Payments in CY 2021:



[1] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2021; Current Population Reports." Issued September 2022. Available at https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf. Accessed October 27, 2022.

The LAN continues to track the barriers and facilitators to APM adoption through informational questions fielded in the survey. The barriers and facilitators to APM adoption have remained steady for all Measurement years. The top three barriers and facilitators for the 2022 Measurement Effort are the following:

Barriers	Facilitators
• Provider willingness to take on financial risk • Provider ability to operationalize • Provider interest/readiness	• Health plan interest/readiness • Government influence • Provider interest/readiness

Overview

APMs have the potential to realign payment incentives and care delivery to improve healthcare quality while reducing costs. The LAN was created to accelerate APM adoption and drive alignment in payment reform approaches across the public and private sectors, adopted and applied goals to the LAN's ongoing initiative. Six years ago, the LAN embarked on its first national APM Measurement Effort to assess the adoption of APMs in the commercial, Medicare Advantage, and Medicaid market segments across the country, with the intention to measure progress toward the goals and to examine how APM adoption is changing over time. The LAN's APM Measurement Effort described in this report marks the sixth year of this initiative.

The LAN recognized the tremendous impact the Public Health Emergency (PHE) had on the industry and the necessity for organizations to prioritize their resources and efforts towards managing and responding to the challenges it has created. Given this, the LAN has decided to revise its APM goals to better suit the reality of the healthcare industry. The variation in the percentages by line of business in the table below reflects that different markets and lines of business are progressing at different rates.

GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models (Categories 3B and 4 of the LAN APM Framework)

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

Note: *The LAN will be seeking public comment on these goals.*

The LAN invited health plans across market segments, as well as FFS Medicaid states, to quantify the amount of in- and out-of-network spending that flows through APMs, including key areas of pharmacy and behavioral health spending, if such data was available. Participating plans and states categorized payments according to the LAN's APM Framework (which was refreshed in 2017), using the LAN survey tool, definitions, and methodology (Figure 1).

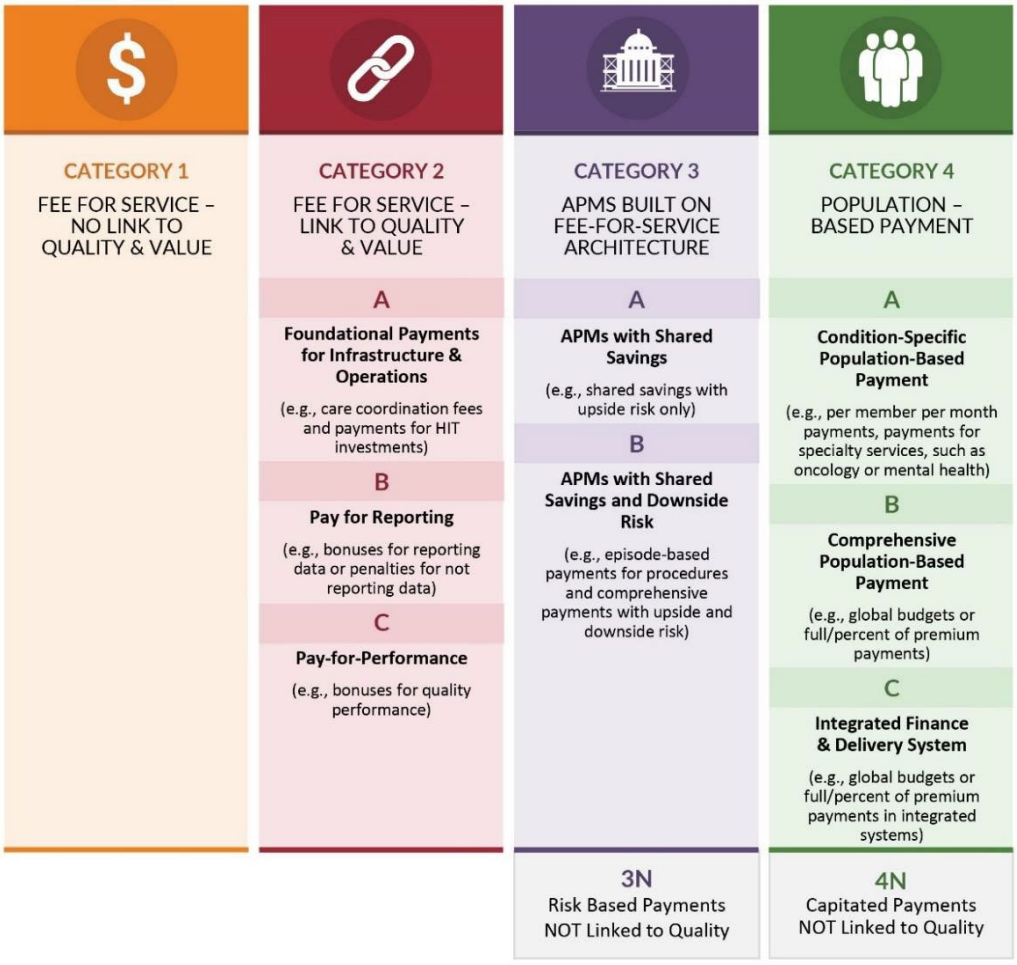


Figure 1: LAN APM Framework

2022 APM Measurement Effort

The LAN launched the 2022 Measurement Effort to collect 2021 APM data on May 23, 2022, and the data collection period concluded on July 30, 2022.

All seven LAN APM Measurement Efforts requested health plans and states to provide retrospective data of actual dollars paid to providers during the previous calendar year (CY) or the most recent 12-month period for which the data was available.

A total of 63 health plans, five FFS Medicaid states, and Traditional Medicare participated in the 2022 Measurement Effort, representing approximately 233,870,081 of the nation's covered lives and 77.7% of the national market. The percentage of the national market is based on a denominator of approximately 300,887,000 lives covered by any health insurance plan.[2] More information on 2022 payment results can be found at https://hcp-lan.org/2022-infographic/.

The results demonstrated the following for payments made during CY 2021:

- 40.5% of healthcare dollars in Category 1
- 19.5% of healthcare dollars in Category 2
- 32.6% of healthcare dollars in Category 3
- 7.4% of healthcare dollars in Category 4

Data Sources

The LAN continued to collaborate with AHIP (formerly known as America's Health Insurance Plans), the Blue Cross Blue Shield Association (BCBSA), and the Centers for Medicare & Medicaid Services (CMS), requesting data from health plans, states, and the Traditional Medicare program. Consistent with the 2020 and 2021 efforts, the LAN, AHIP, and BCBSA included informational questions about the future of APM adoption and collected payment data by line of business (i.e., commercial, Medicaid, Medicare Advantage, and Traditional Medicare), and at the payment level within the various subcategories (e.g., pay-for-performance, shared risk).[3] This granular data provides actionable insights into the state of APMs in the different market segments, and the qualitative insights collected through the informational questions help enhance the quantitative results by identifying the potential future trajectory of APMs.

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[2] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2021; Current Population Reports." Issued September 2022. Available at https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf. Accessed October 27, 2022.

[3] In the 2020 measurement survey, the LAN and partner organizations piloted a voluntary metric related to the measurement of nominal risk for entities with shared risk arrangements (3B). The metric is viable, but it did not yield sufficient responses, so the LAN and partner organizations agreed to remove this metric from the 2021 and 2022 survey.

Health plans had multiple paths to contribute to the LAN APM Measurement Effort. In addition to the LAN's data collection efforts (see the LAN Survey section below), AHIP and BCBSA fielded surveys to their member health plans in 2022. All three avenues of data collection requested that health plans report the total dollars paid to providers by line of business and at the payment method level. AHIP and BCBSA identified health plans that are members of both organizations and coordinated to ensure there were no duplicate responses in the respective data sets.

The 2022 LAN APM Measurement Effort combined data from the AHIP survey, the BCBSA survey, the LAN survey, and Traditional Medicare data. Health plans, states, and Traditional Medicare reported the total dollars paid to providers through the payment methods within the subcategories according to the refreshed LAN APM Framework. With this data, the LAN calculated aggregate results for 2022 by line of business and at the payment method level by category and subcategory.

The LAN Survey

The 2022 LAN data collection period to capture CY 2022 data started on May 23, 2022, and concluded on July 30, 2022.

The LAN used metrics to determine the extent of APM adoption, asking health plans and states to report dollars paid in CY 2021 or in the most recent 12 months for which it had data. Health plan and state participation, as well as individual data, was kept confidential. In order to maintain the impartiality and participant confidentiality of the Department of Health and Human Services (HHS), the LAN Operator and not HHS, received, analyzed, and aggregated all individual plan and state data.

Because most payment innovations typically incorporate multiple payment methods (e.g., FFS plus a care coordination fee and shared savings), plans and states were asked to report dollars paid according to the most dominant or advanced payment method they used (e.g., shared savings or condition-specific population-based payments). The LAN reviewed health plan responses to identify outlier or inconsistent data and provided follow-up questions to plans and states to support data integrity. Health plans and states either clarified or modified their responses as appropriate.

The method for calculating the metrics required health plans and states to retrospectively examine the actual payments they made to providers in CY 2021 (or in the most recent 12 months for which they had data) through the different APMs and categorize them accordingly. For APMs in Categories 3 and 4, some of which hold providers accountable for their patients' total cost of care, health plans could report dollars paid based on members attributed to the method.[4]

The data collected through the LAN survey is described in Table 1 and Appendix A Table 1. AHIP and BCBSA collected data identical to that collected through the LAN survey (see AHIP Survey and Blue Cross Blue Shield Association Survey and sections below).

Merging the Data

The LAN merged the data elements from the AHIP and BCBSA surveys, Traditional Medicare, along with those submitted directly to the LAN.

The AHIP Survey

The 2022 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 LAN APM Framework. AHIP recruited its member health plans through email and phone outreach. Using a key informant approach, AHIP initially 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

[4] For more information and guidance on categorizing payments, including capitation without quality, see the National APM Data Collection Frequently Asked Questions for 2022.

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 LAN.

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

The Blue Cross Blue Shield Association Survey

To collect the data points in Table 1 and Appendix A Table 1, BCBSA included questions in an annual survey of member plans addressing the delivery of value-based healthcare. BCBSA collaborated with the LAN and AHIP to ensure alignment of survey questions to facilitate data aggregation.

BCBSA reported the data elements in Table 1 and Appendix A Table 1, and those listed below, in aggregate to the LAN for the purposes of measuring multiple payers' adoption of APMs nationally:

- Total number of participating plans
- Total number of covered lives by participating plans

The data elements listed below reflect 2021 data and were submitted to, validated by, and aggregated by BCBSA. Data was collected for healthcare spending paid to all providers for dates of service in CY 2021 (January 1 to December 31) or the most recent 12-month period, while the covered lives data point was requested as a "point in time" for June 30, 2022.

Traditional Medicare

CMS reported Traditional Medicare spending in CY 2021 to the LAN. CMS also collaborated with AHIP, BCBSA, and the LAN to align methodologies and facilitate data aggregation for reporting national progress. The CY 2021 Medicare Parts A and B data elements that were reported to the LAN are the data elements in Table 1, which include the total dollars paid to providers participating in Traditional Medicare APMs in CY 2021 by subcategory and category.

The Traditional Medicare results are considered interim because they are based on only three quarters of CY 2021 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 alternative payment models CMS used to calculate the percent of payments made through Categories 3 and 4 of the APM Framework in CY 2021 include shared savings, shared risk, bundled payments, and population-based payment models. The most recent 2021 CMS Office of the Actuary (OACT) annual Part A and B expenditure data is used to calculate the denominator and is obtained directly from OACT.

Table 1: 2022 Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2021 or most recent 12 months.	*Denominator to inform the metrics below.*

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 1 (METRICS ARE NOT LINKED TO QUALITY)	
Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2021 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 2021 or most recent 12 months.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2021 or most recent 12 months. (Subcategory 2A)	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2021 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-reporting** payments (linked to quality) in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-performance** payments (linked to quality) in CY 2021 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 2021 or most recent 12 months.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid in **Category 2** in CY 2021 or most recent 12 months.	Payment Reform – APMs built on fee-for-service linked to quality: Percent of total dollars paid in Category 2.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 3 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2021 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 2021 or most recent 12 months.
Total dollars paid in **Category 3** in CY 2021 or most recent 12 months.	Payment Reform – APMs built on fee-for-service architecture: Percent of total dollars paid in Category 3.

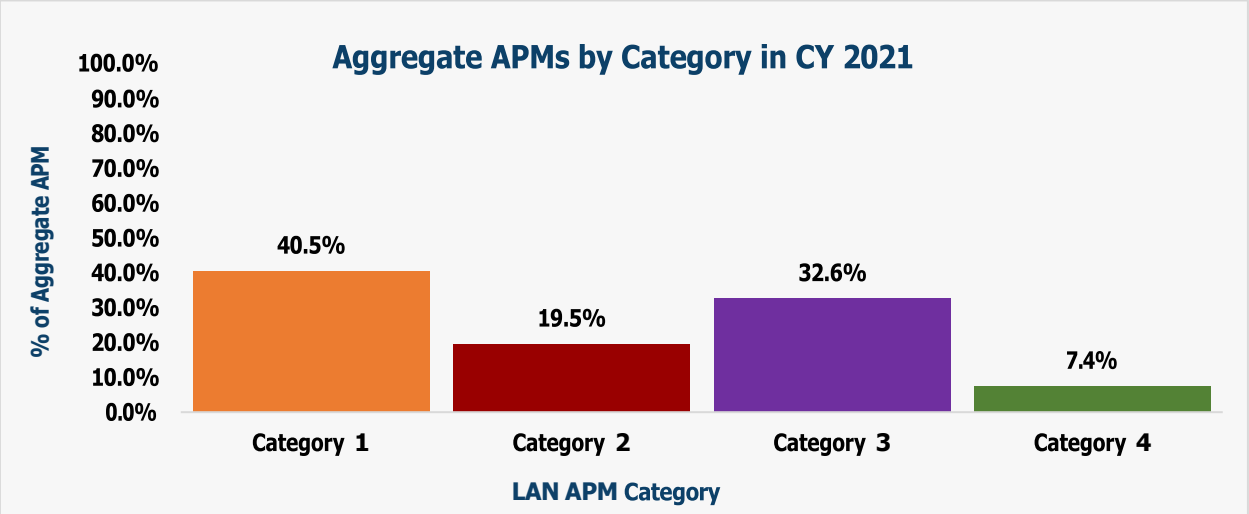
NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 4 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2021 or most recent 12 months. (Subcategory 4A)	Condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific, population-based payments (linked to quality) in CY 2021 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2021 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 2021 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery system programs** (linked to quality) in CY 2021 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 2021 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2021 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

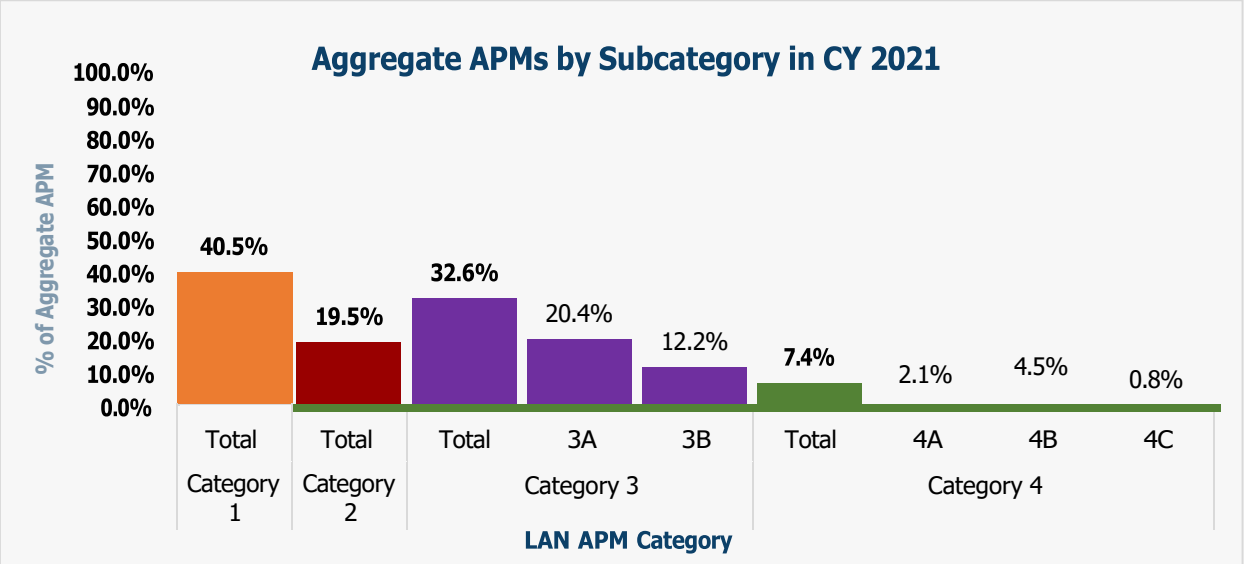
Results: Payments Made in CY 2021

Results are presented by line of business (Aggregate, Commercial, Medicaid, Medicare Advantage, and Traditional Medicare) in the sections below.

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

The combined LAN, BCBSA, AHIP, and Traditional Medicare data, representing 77.7% of the national market in 2021 [5] shows the following subcategory level payments made to providers in CY 2021 in all lines of business:





[5] 63 health plans, 5 states, Traditional Medicare in 2021.

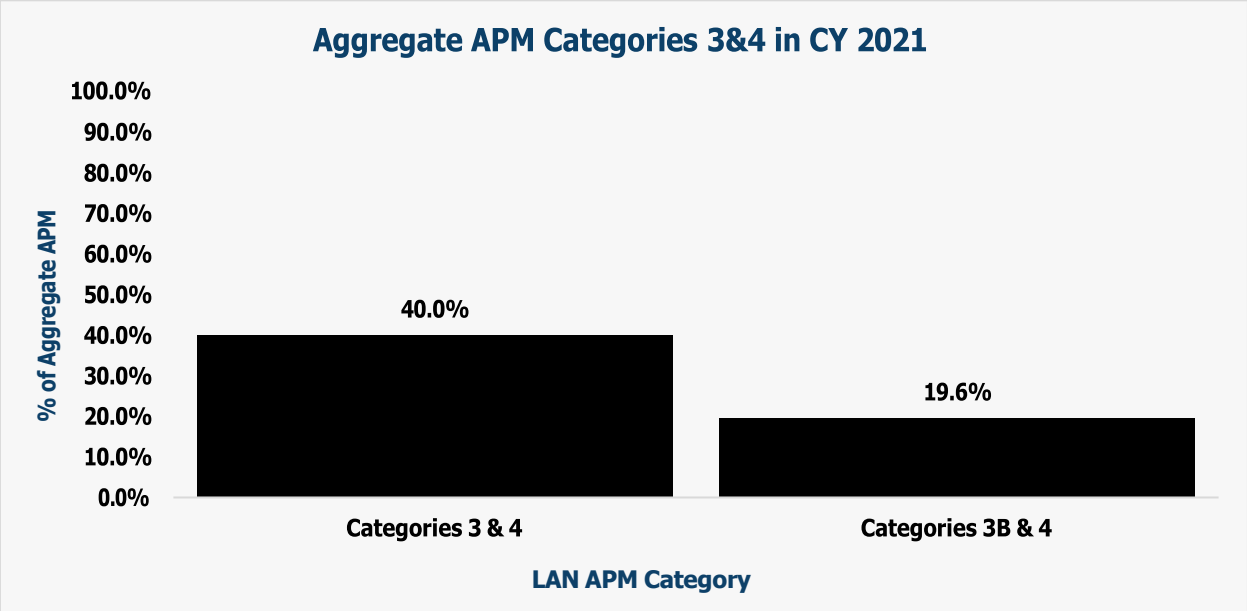


Table 2: Responses to the Informational Questions

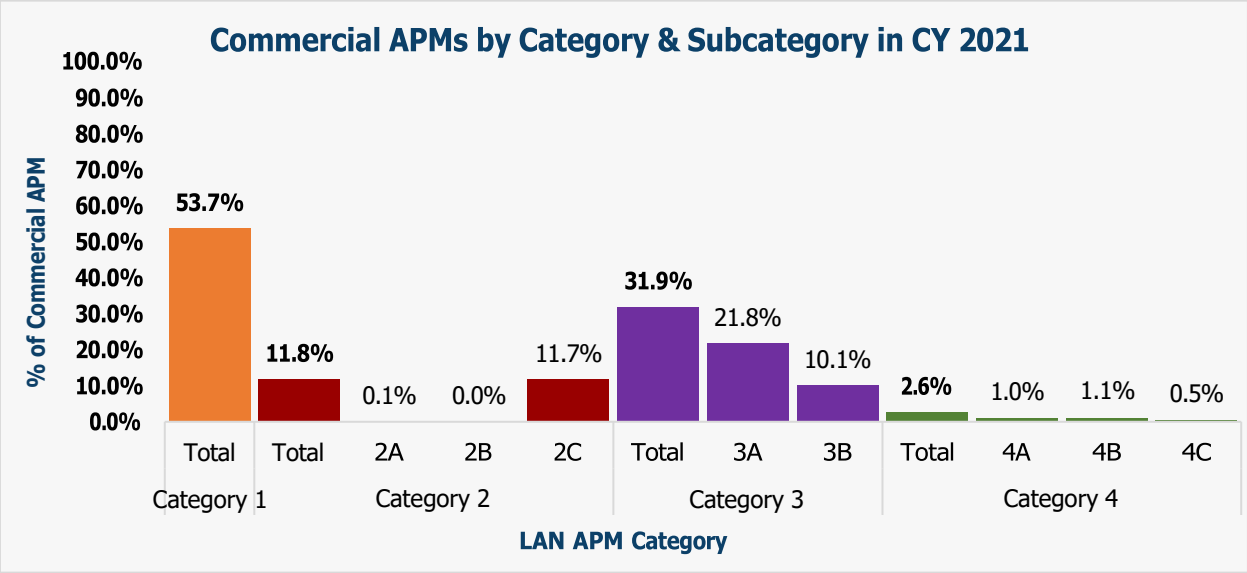
INFORMATIONAL QUESTIONS IN 2022 MEASUREMENT SURVEY				
PAYERS WHO THINK APM ACTIVITY:	*WILL INCREASE*	*WILL STAY THE SAME*	*WILL DECREASE*	*PAYERS WHO ARE NOT SURE/DECLINED TO RESPOND*
	83.0%	13.0%	0.0%	4%
PAYERS STATING THAT THE APM SUBCATEGORY THAT WILL INCREASE THE MOST WILL BE:				
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments **(3B)**				34.0%
• Traditional shared-savings, Utilization-based shared-savings **(3A)**				24.0%
TOP THREE BARRIERS TO APM ADOPTION AS IDENTIFIED BY PAYERS SAME RESPONSES AND ORDER IN 2021				
1. Provider willingness to take on financial risk 2. Provider ability to operationalize 3. Provider interest/readiness				

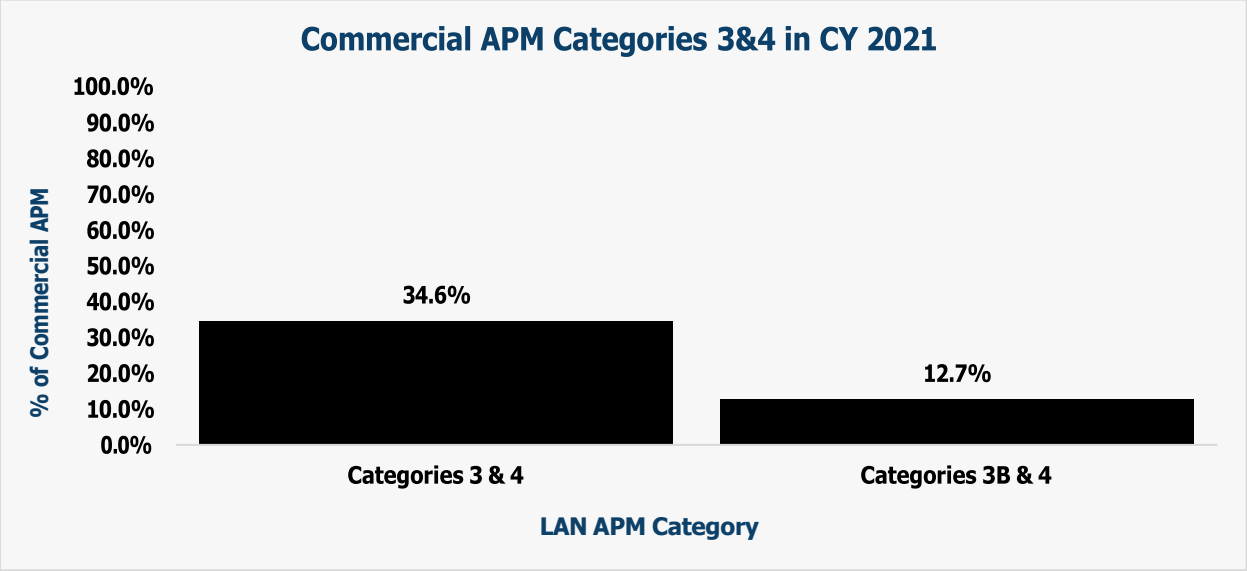
INFORMATIONAL QUESTIONS IN 2022 MEASUREMENT SURVEY		
TOP THREE FACILITATORS TO APM ADOPTION AS IDENTIFIED BY PAYERS SAME RESPONSES AND ORDER IN 2021		
1. Health plan interest/readiness 2. Government influence 3. Provider interest/readiness		
PAYERS WHO AGREE OR STRONGLY AGREE WITH AND PAYERS WHO DISAGREE OR STRONGLY DISAGREE WITH THE FOLLOWING: [6]	*AGREE/ STRONGLY AGREE*	*DISAGREE/ STRONGLY DISAGREE*
• APM adoption will result in better quality of care	96.0%	4.0%
• APM adoption will result in more affordable care	82.0%	6.0%
• APM adoption will result in improved care coordination	96.0%	4.0%
• APM adoption will result in more consolidation among healthcare providers	41.0%	37.0%
• APM adoption will result in higher unit prices for discrete services	10.0%	56.0%
• Other (please list)	0.0%	0.0%

[6] The percentages for each outcome do not add up to 100% because the "not sure" responses were removed from the data reported here.

Commercial

The commercial data, representing 62.3% of the national market in 2021,[7] shows the following for payments made to providers in CY 2021:

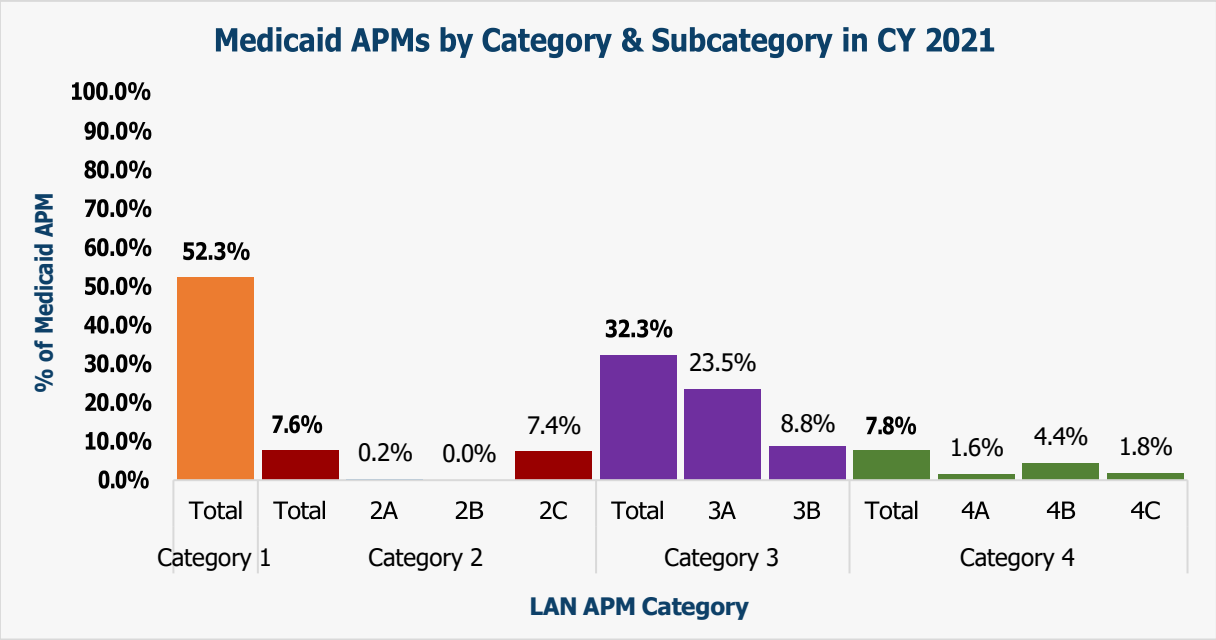


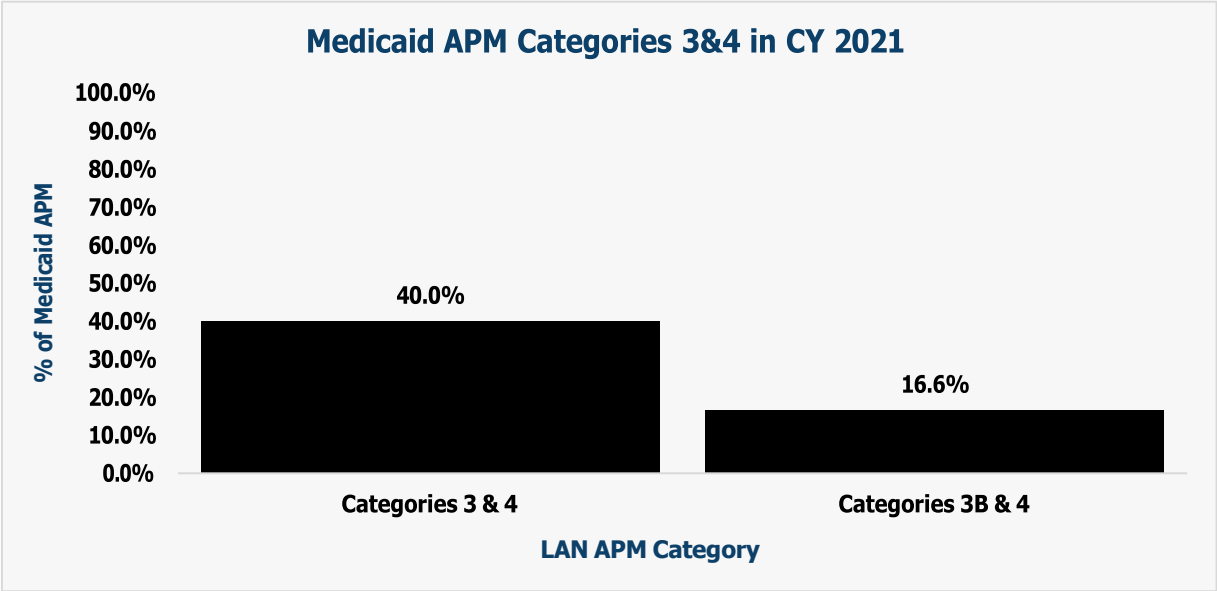


[7] See footnote 3.

Medicaid

The Medicaid data, representing 61.6% of the national Medicaid market (*excluding* enrollees who are dually eligible for Medicare and Medicaid coverage) in 2021,[8] shows the following for payments made to providers in CY 2021:

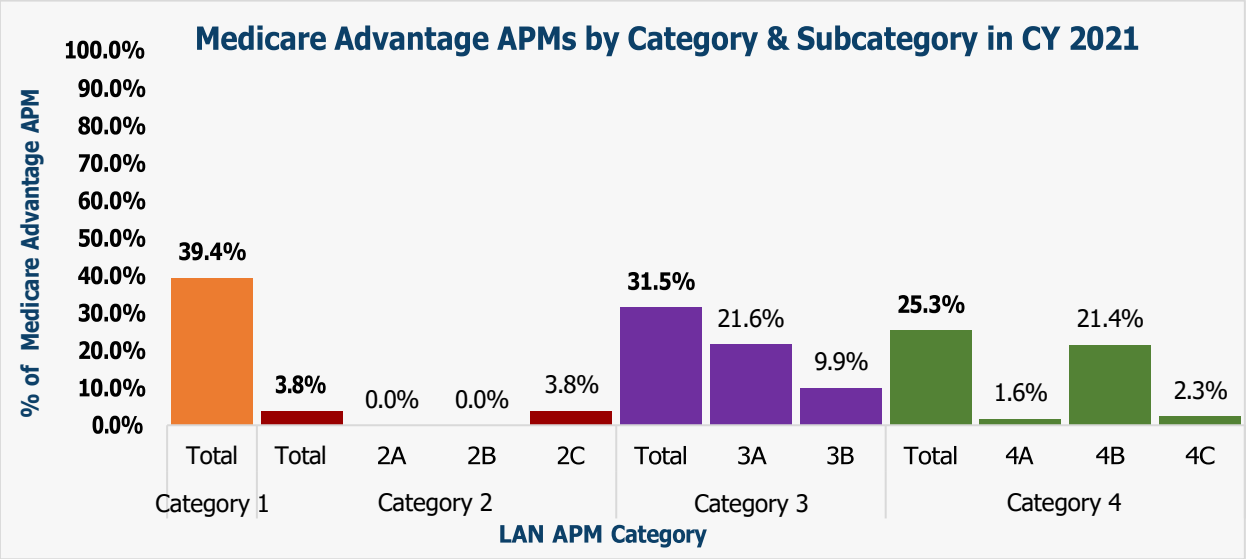


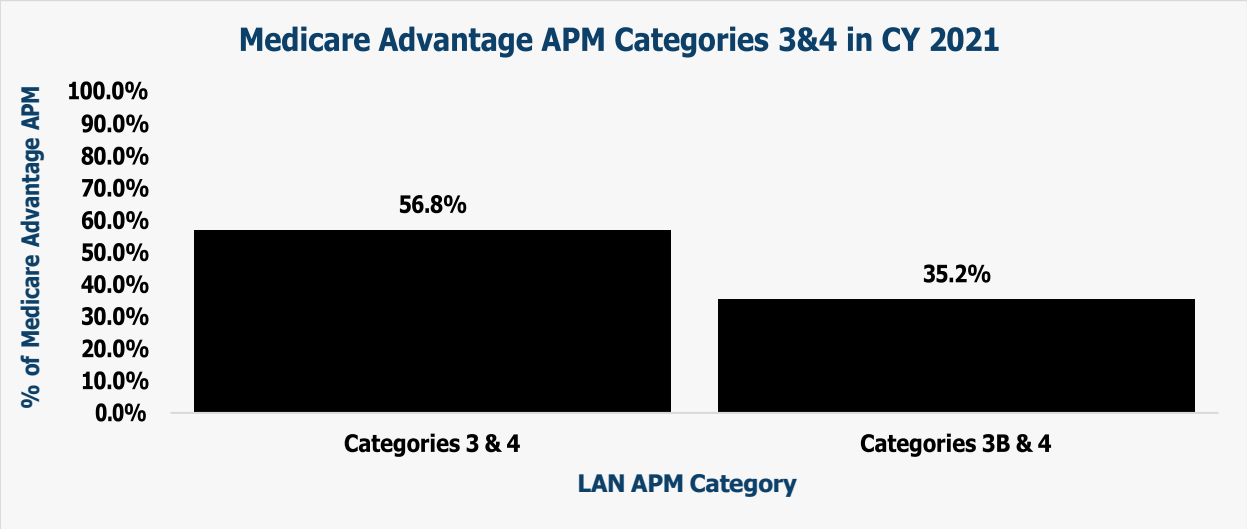


[8] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," August 2022. Available at CMSFastFactsAug2022.pdf. Accessed October 27, 2022.

Medicare Advantage

The Medicare Advantage data, representing 68.5% of the national Medicare Advantage market (*including* enrollees who are dually eligible for Medicare and Medicaid coverage) in 2021,[9] shows the following for payments made to providers in CY 2021:

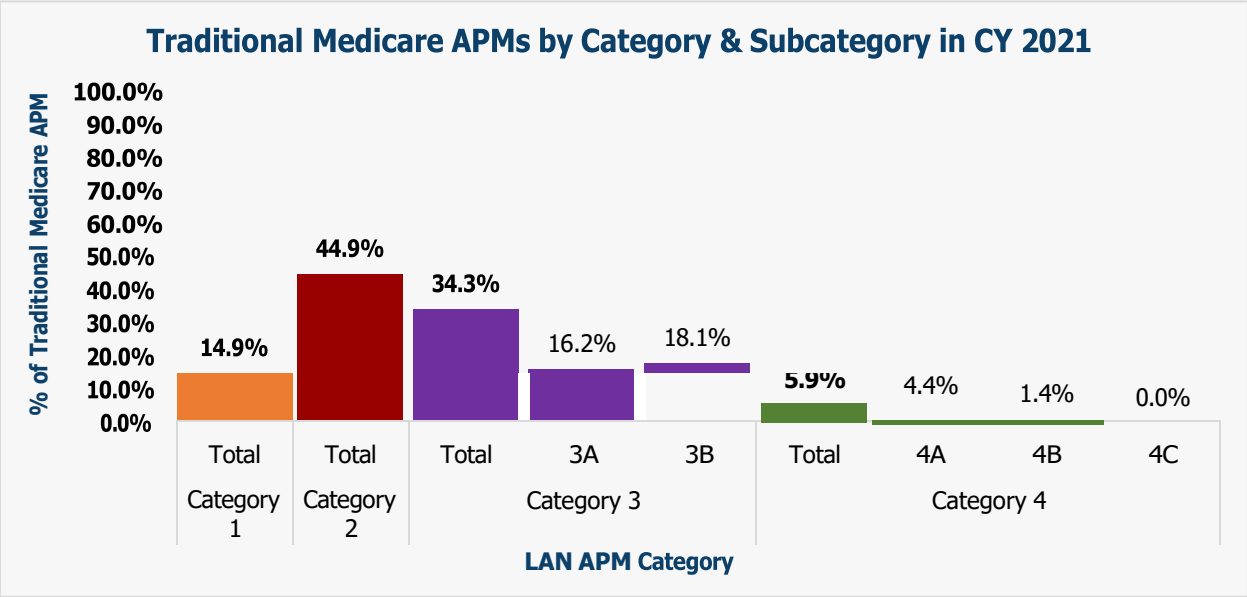




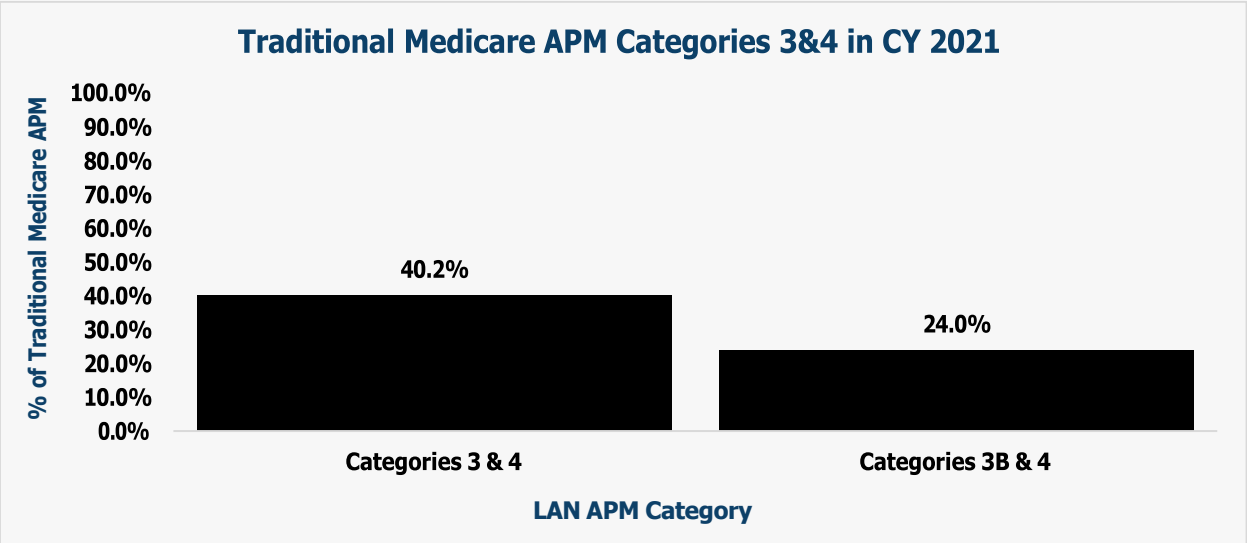
[9] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," August 2022. Available at https://data.cms.gov/sites/default/files/2022-08/4f0176a6-d634-47c1-8447-b074f014079a/CMSFastFactsAug2022.pdf. Accessed October 27, 2022. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," March 2021. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics. Accessed October 27, 2022.

Traditional Medicare

The Traditional Medicare data, representing 36,400,000 Traditional Medicare beneficiaries, which is 100% of the Traditional Medicare market,[10] shows the following for payments made to providers in CY 2021:



Note: Due to rounding, the sum of categories may not add up to 100.0%.



Note: Due to rounding, the sum of categories may not add up to 100.0%.

[10] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," August 2022. Available at CMSFastFactsAug2022.pdf. Accessed October 27, 2022.

Limitations

Health Plan and State Participation Is Voluntary: The LAN data, combined with the AHIP, BCBSA, and Traditional Medicare data reported at the subcategory level, represents 77.7.% of the covered lives in the United States in 2021. The Measurement Effort did not have full participation from all health plans and states, nor did it capture 100% of the lives covered by health insurance. Furthermore, health plan and state participation in the LAN, BCBSA, or AHIP surveys was voluntary. 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, potentially driving Categories 2-4 results upward.

Potential Variation in the Interpretation of the Metrics: The LAN worked to facilitate a consistent interpretation of the APM categories, subcategories, and 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 APM Framework, 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 2021, which could reflect lower levels of APM adoption.

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

Appendix A: 2022 Measurement Effort Informational Questions

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-savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system 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-savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure

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 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 healthcare providers (strongly disagree, disagree, agree, strongly agree, not sure) • Higher unit prices for discrete services (strongly disagree, disagree, agree, strongly agree, not sure) • Other (please list) (strongly disagree, disagree, agree, strongly agree, not sure)

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 LAN and this APM measurement effort.

Table 2: Definitions

TERMS	DEFINITIONS
Alternative Payment Model (APM)	Healthcare payment methods that use financial incentives to promote or leverage greater value—including higher quality care at lower costs—for patients, purchasers, payers, and providers. This definition is specific to this exercise. If you are interested in MACRA's definition, please reference MACRA for more details. Refreshed APM Framework White Paper MACRA Website
Appropriate care measures	Appropriate care measures are metrics that are based on evidence- based guidelines and comparative effective research. Such measures assess how well providers avoid unnecessarily costly, harmful, and unnecessary procedures. These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g., Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to, unnecessary readmissions, preventable admissions, unnecessary imaging, 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.
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.

TERMS	DEFINITIONS
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 fee-for-service architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers who meet their quality, and cost or utilization targets are eligible to share in savings, and those who do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. See definition of "appropriate care measures" for a description and examples.
Category 4	 Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.

TERMS	DEFINITIONS
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 2019/2020 or the most recent 12-month period for which data is available. Spending for dental and vision services are 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 healthcare 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**]
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 2021 or most recent 12 months	Calendar year (CY) 2021 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."

TERMS	DEFINITIONS
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.
Fee-for-service (FFS)	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes, or efficiency. [APM Framework Category **1**]
Foundational spending	Includes, but is not limited to, payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists. [APM Framework Category **2A**]
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g., inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B**]
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**]

TERMS	DEFINITIONS
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.
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: healthcare spending for dual eligible beneficiaries, healthcare 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 2021 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 2021 or the most recent 12-month period for which data is available. Dental and vision services are excluded.

TERMS	DEFINITIONS
Pay-for-performance	The use of incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. [APM Framework Categories **2C**]
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 healthcare 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 healthcare 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**]

TERMS	DEFINITIONS
Total Dollars	The total estimated in- and out-of-network healthcare spend (e.g., annual payment amount) made to providers in CY 2021 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**]

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

The CMS Alliance to Modernize Healthcare federally funded research and development center (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 the Centers for Medicare & Medicaid Services (CMS) on behalf of Department of Health and Human Services (HHS), the LAN Operator serves as an objective advisor to all HHS organizations and other federal agencies with health and human services missions. The LAN 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.