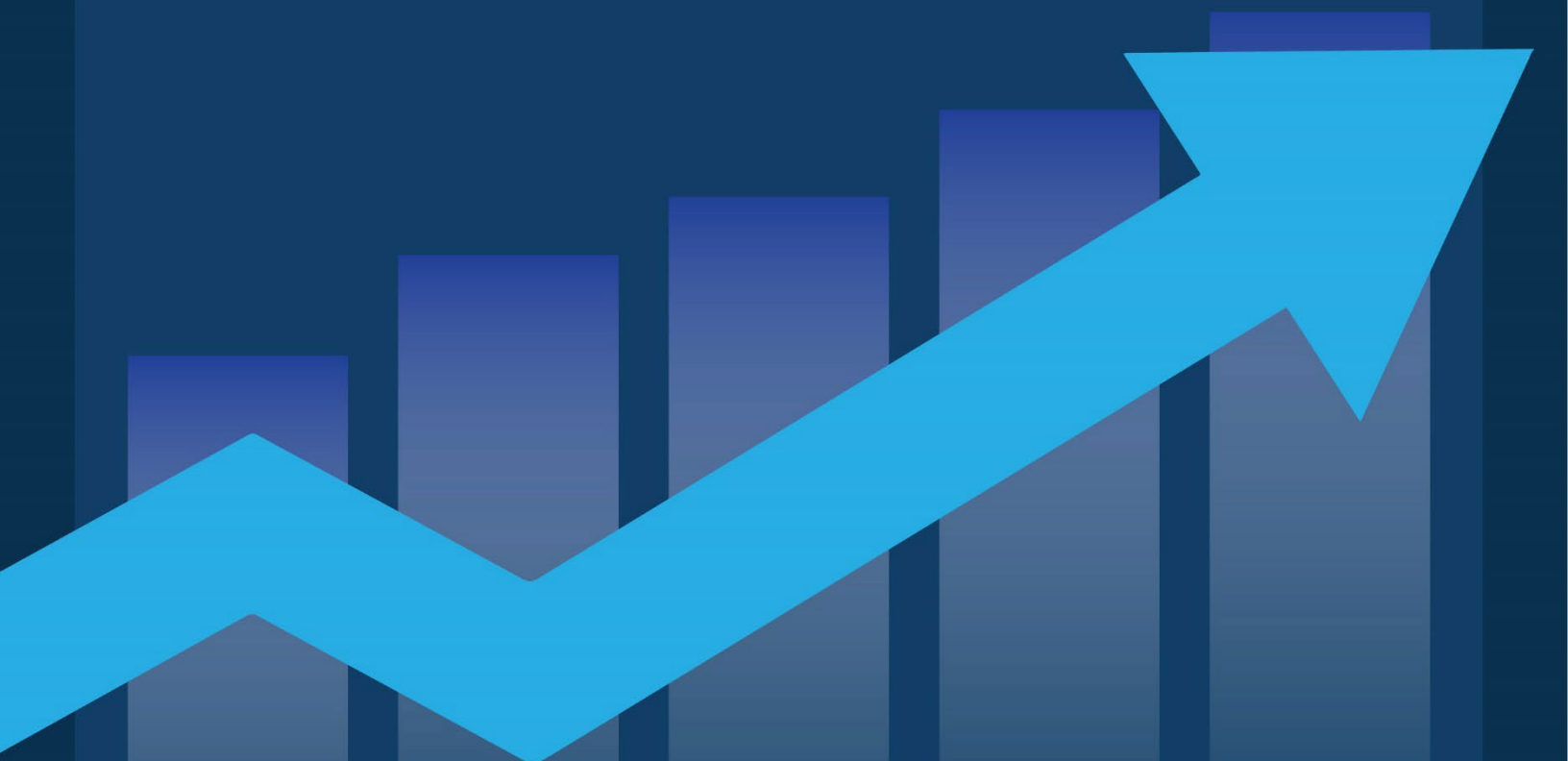
APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS



2023 Methodology and Results Report

HCPLAN

Health Care Payment Learning & Action Network

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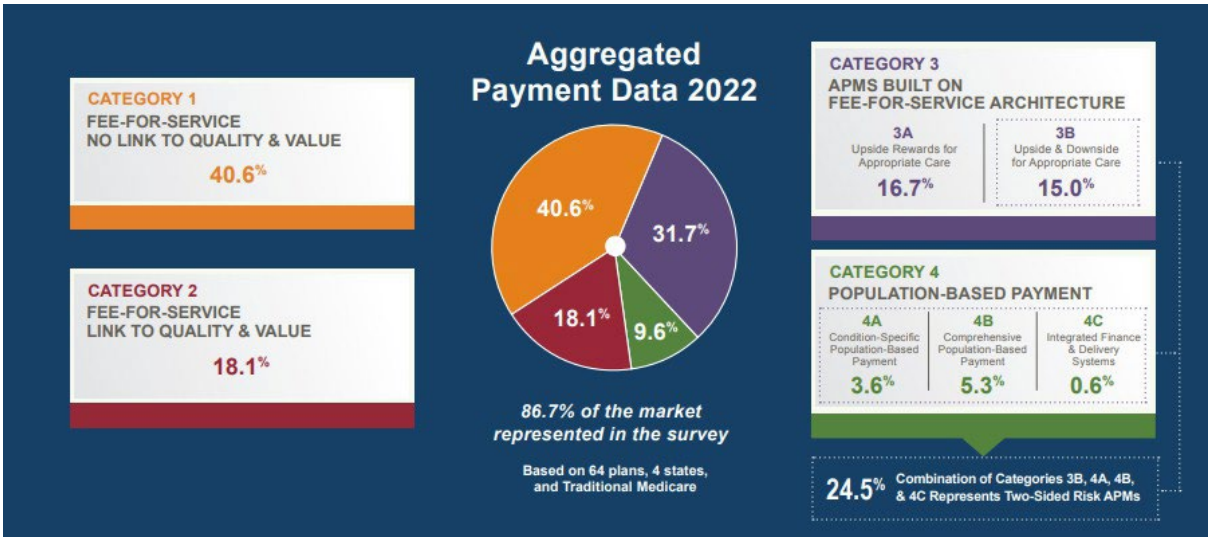
Executive Summary

The 2023 Health Care Payment Learning & Action Network (LAN) Measurement Effort initiated its annual alternative payment model (APM) survey in May 2023 and concluded at the end of July 2023. Health plans, states, and Traditional Medicare provided retrospective data on actual dollars paid to providers during calendar year (CY) 2022 or the most recent 12-month period for which the data was available. A total of 64 health plans, four fee-for-service (FFS) Medicaid states, and Traditional Medicare participated in the 2023 LAN Measurement Effort representing almost 264 million or 86.7% of people covered by an insurance plan in the Commercial, Medicare Advantage, Medicaid, or Traditional Medicare markets.[1]

The 2023 APM results highlight payments made during CY 2022 for all lines of businesses combined. The payments were categorized based on the LAN APM Framework (Figure 1).

Figure 1: Aggregated APM Payments in CY 2022



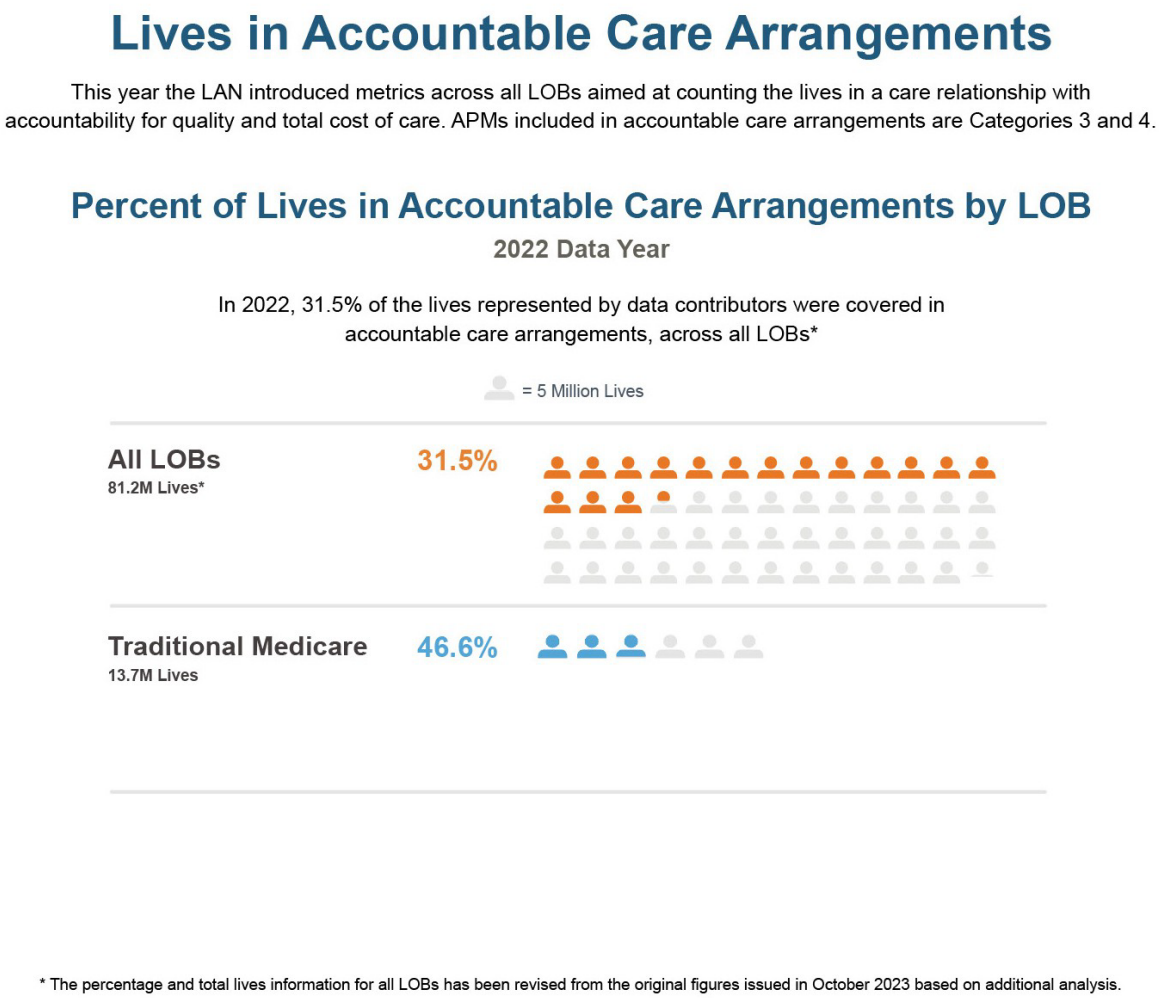
The LAN continues to track the barriers and facilitators to APM adoption through informational questions fielded in the survey and the results have remained steady for all measurement years. Additionally, the LAN remains interested in how APMs are being used to address in care. For most frequently reported strategies, see Table 3: Responses to the Informational Questions.

Finally, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation, also known as the CMS Innovation Center, set goals of having 100% of Medicare beneficiaries in Parts A and B and the vast majority of Medicaid beneficiaries in an accountable care

[1] The percentage of the national market is based on a denominator of approximately 304,000,000 lives covered by any health insurance plan. U.S. Census Bureau, "Health Insurance Coverage in the United States: 2021; Current Population Reports." Issued September 2022. Available at Health Insurance Coverage in the United States: 2021 (census.gov). Accessed October 11, 2023.

relationship. The first-ever accountable care data shows the following for the number of lives in accountable care arrangements during CY 2022 for all lines of business (Figure 2). In 2022, 31.5%* of the lives represented by data contributors were covered in accountable care arrangements, across all LOBs.

Figure 2: Lives in Accountable Care Arrangements in CY 2022



* The percentage and total lives information for all LOBs has been revised from the original figures issued in October 2023 based on additional analysis.

Overview of APM Measurement Effort

APMs have the potential to realign payment incentives and care delivery to improve health care 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. Seven years ago, the LAN launched 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. All past APM Measurement Methodology and Results Reports are available to view on the APM Measurement Effort Results page on the LAN website.

The LAN recognizes the tremendous impact the COVID-19 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 created. Given this, the LAN has decided to revise its APM goals to better suit the reality of the health care 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 (Figure 3).

Figure 3: LAN APM Goals

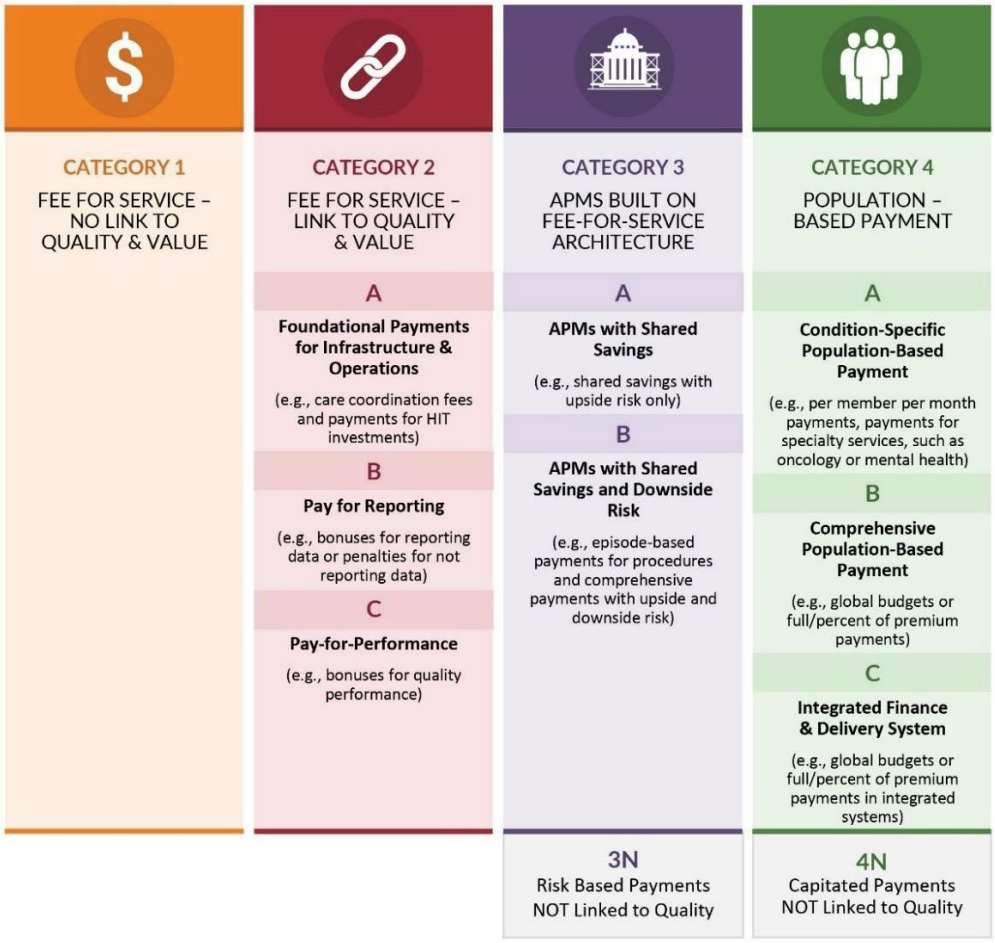
GOAL STATEMENT

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%

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, using the LAN's survey tool, definitions, and methodology (Figure 4).

Figure 4: LAN APM Framework



2023 APM Measurement Effort Methodology

The LAN launched the 2023 APM Measurement Effort to collect 2022 APM data on May 22, 2023, and the data collection period concluded on July 31, 2023. 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, or the most recent 12-month period for which the data was available.

A total of 64 health plans, four FFS Medicaid states, and Traditional Medicare participated in the 2023 Measurement Effort, representing almost 264 million or 86.7% of people covered by an insurance plan in the Commercial, Medicare Advantage, Medicaid, or Traditional Medicare markets. The percentage of the national market is based on a denominator of approximately 304,000,000 lives covered by any health insurance plan.[2]

Data Sources

The LAN continued to collaborate with AHIP, the Blue Cross Blue Shield Association (BCBSA), and CMS, requesting and aggregating data from health plans, states, and the Traditional Medicare program. In addition to the LAN's data collection efforts (see The LAN Survey section), AHIP and BCBSA fielded surveys to their member health plans in 2023. 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. All three surveys requested that health plans report the total dollars paid to providers by line of business and at the payment method level.

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 2023 by line of business and at the payment method level by category and subcategory. The LAN also aggregated responses from all participating entities to determine the lives in accountable care arrangements across lines of business.

Consistent with the 2022 APM Measurement Effort, the LAN, AHIP, and BCBSA included informational questions about the future of APM adoption. 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.

For the 2023 APM Measurement Effort, the LAN expanded the survey by including metrics aimed at measuring lives in accountable care arrangements. Individual payers informed the initial development of these metrics, and the LAN refined the metrics in consultation with AHIP, BCBSA, and CMS. All entities agreed to field these questions in the 2023 APM Measurement Effort survey. All

[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 October11, 2023.

survey changes were communicated to participating payers during training webinars and through the Frequently Asked Questions resource for participating payers.

Finally, the LAN survey gave organizations the option to be recognized for their data contributions, while maintaining the confidentiality of their individual data.

The LAN Survey

The 2023 LAN data collection period to capture CY 2022 data started on May 22, 2023 and concluded on July 31, 2023.

The LAN used metrics to determine the extent of APM adoption, asking health plans and states to report dollars paid in CY 2022, 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. To maintain impartiality and participant confidentiality, the LAN Operator[3] - and not the United States Department of Health and Human Services (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 Operator 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 APM metrics required health plans and states to retrospectively examine the actual payments they made to providers in CY 2022 (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 Table 2 and Appendix A's Table 1.

The AHIP Survey

The 2023 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. 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 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 LAN.

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

[4] For more information and guidance on categorizing payments, including capitation without quality, see the National APM Data Collection Frequently Asked Questions for 2023.

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 Table 2 and Appendix A's Table 1, 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 LAN and AHIP to ensure alignment of survey questions to facilitate data aggregation.

BCBSA reported the data elements in Table 1 and Table 2 and Appendix A's 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

Data was collected for health care spending paid to all providers for dates of service in CY 2022 (January 1 to December 31) or the most recent 12-month period, and the covered lives data point was requested for the same time period (January 1 to December 31). The data elements listed above reflect 2022 data and were submitted to, validated by, and aggregated by BCBSA.

Traditional Medicare

CMS reported Traditional Medicare spending in CY 2022 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 2022 Medicare Parts A and B data elements that were reported to the LAN are the data elements in Table 1 and Table 2, which include the total dollars paid to providers participating in Traditional Medicare APMs in CY 2022 by subcategory and category 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 2022 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 2022 include shared savings, shared risk, bundled payments, and population-based payment models. The most recent 2022 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.

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 data elements that were merged from all entities included measuring the dollars associated with APMs and counting the number of lives in accountable care arrangements. A description of each entities' data collection process is described below.

2023 APM Quantitative Survey Data Elements

The quantitative data collected through the LAN survey includes metrics that are based on the APM Framework and the CMS Innovation Center's Strategy Refresh. For more information, see Table 1 and Table 2 below.

Table 1: 2023 APM Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2022 or most recent 12 months.	Denominator to inform the metrics below.

NUMERATOR	DESCRIPTION OF METRIC
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 2022 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 2022 or most recent 12 months.
CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2022 or most recent 12 months. (Subcategory 2A)	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2022 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-reporting** payments (linked to quality) in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through fee-for-service plus pay-for-performance payments (linked to quality) in CY 2022 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 2022 or most recent 12 months.
Total dollars paid in **Category 2** in CY 2022 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
CATEGORY 3 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2022 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 2022 or most recent 12 months.
Total dollars paid in **Category 3** in CY 2022 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)	
Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2022 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 2022 or most recent 12 months.

NUMERATOR	DESCRIPTION OF METRIC
Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2022 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 2022 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery system programs** (linked to quality) in CY 2022 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 2022 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2022 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

Table 2: 2023 Lives in Accountable Care Arrangements Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total number of health plan members in CY 2022 or most recent 12 months reported by survey respondents.	*Denominator to inform the metrics below.*

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 2022 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 2022 or most recent 12 months.

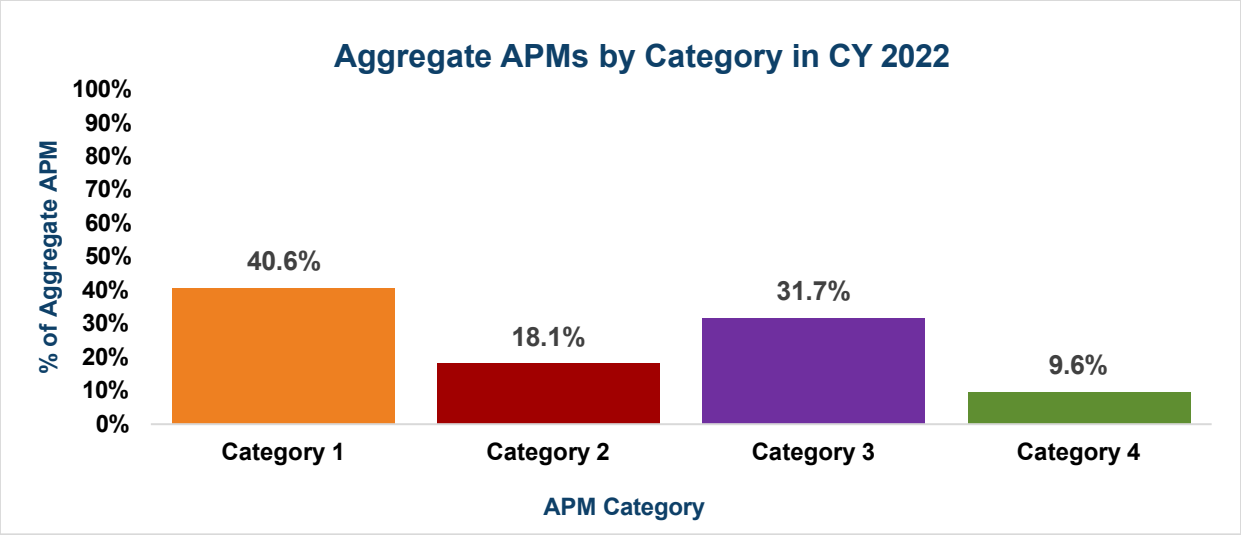
Results

Payments Made in CY 2022

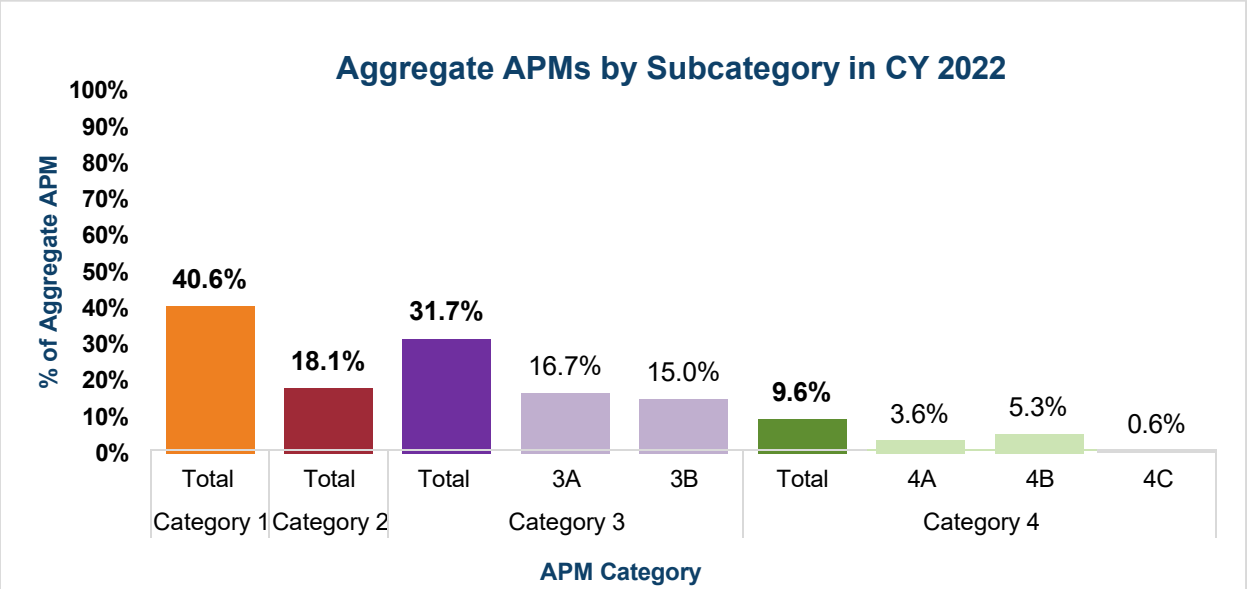
Results are presented by line of business (Aggregate, Commercial, Medicaid, Medicare Advantage, and Traditional Medicare) in the sections below.

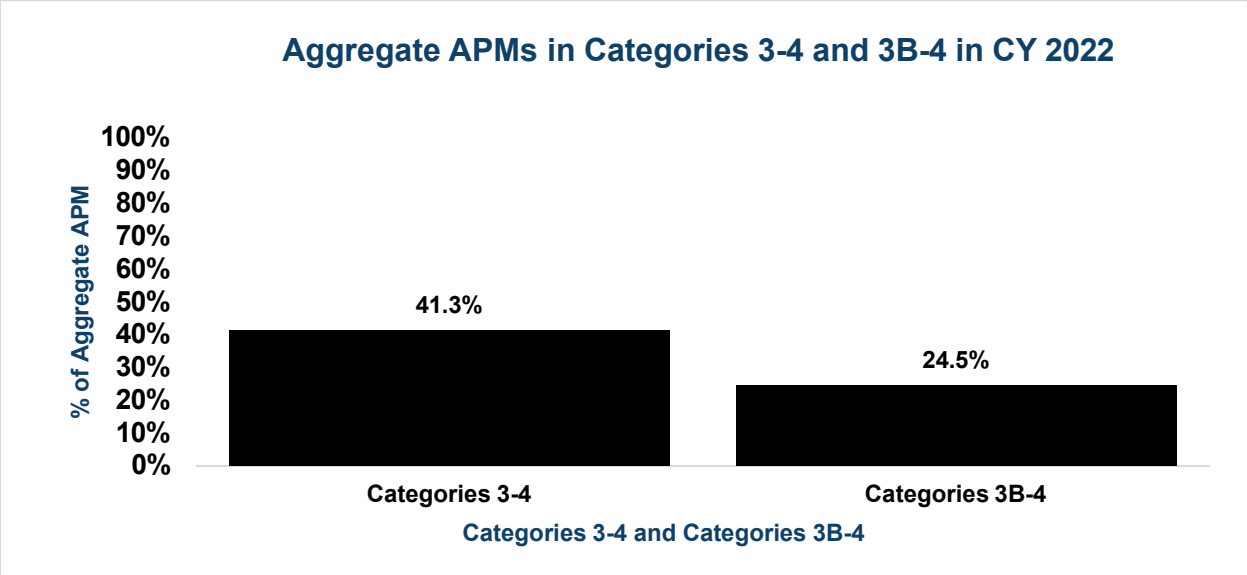
Aggregate – All lines of business of respondents reporting at the subcategory level

The combined LAN, BCBSA, AHIP, and Traditional Medicare data, representing 86.7% of the national market in 2022[5] shows the following category and subcategory level payments made to providers in CY 2022 in all lines of business:



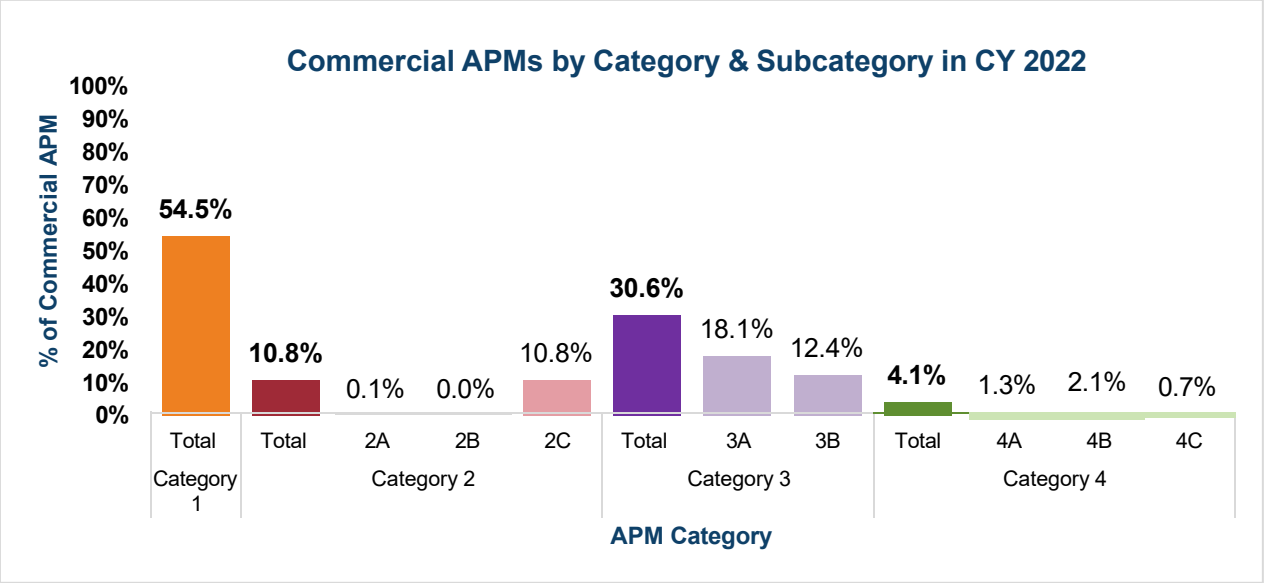
[5] 64 health plans, 4 states, Traditional Medicare in CY 2022.

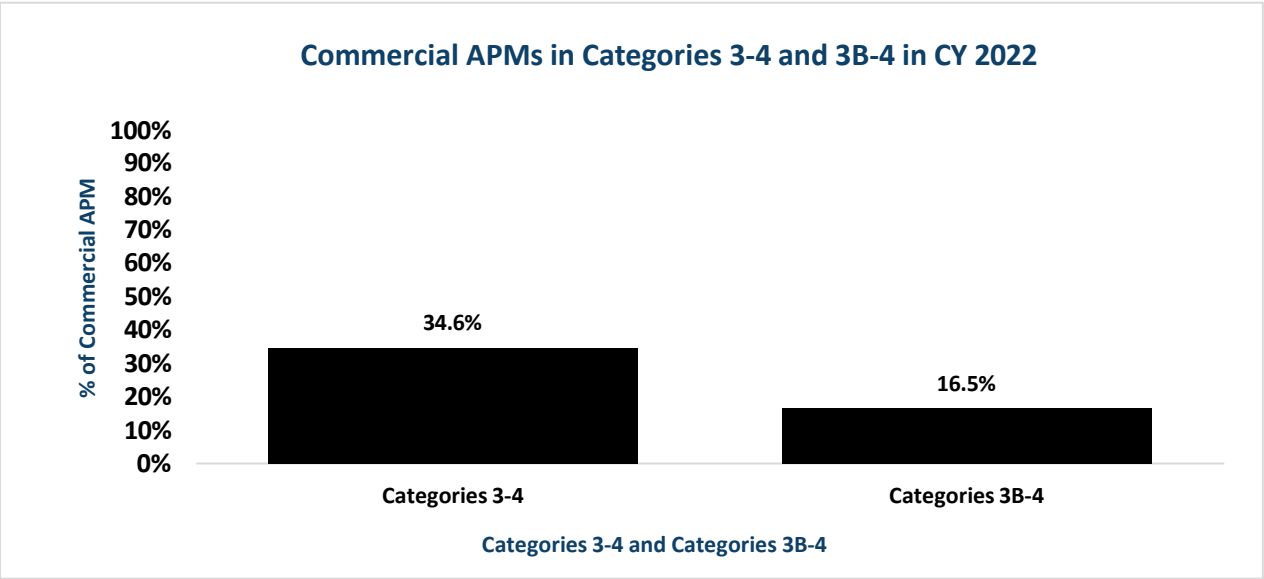




Commercial

The Commercial data, representing 69.4% of the national market in 2022,[6] shows the following for payments made to providers in CY 2022:

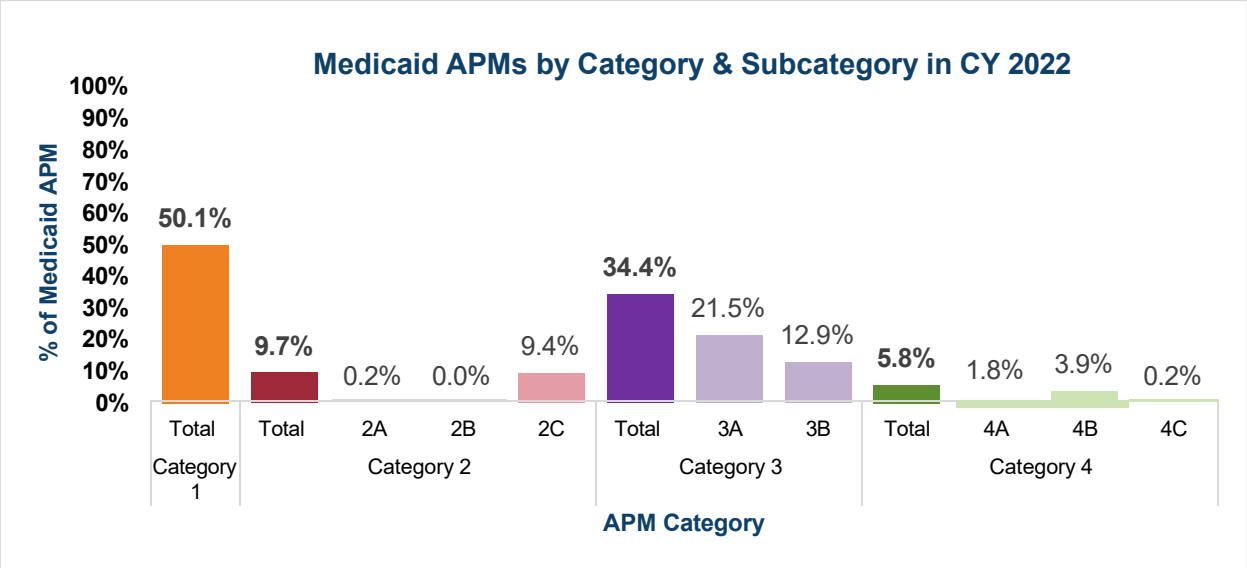


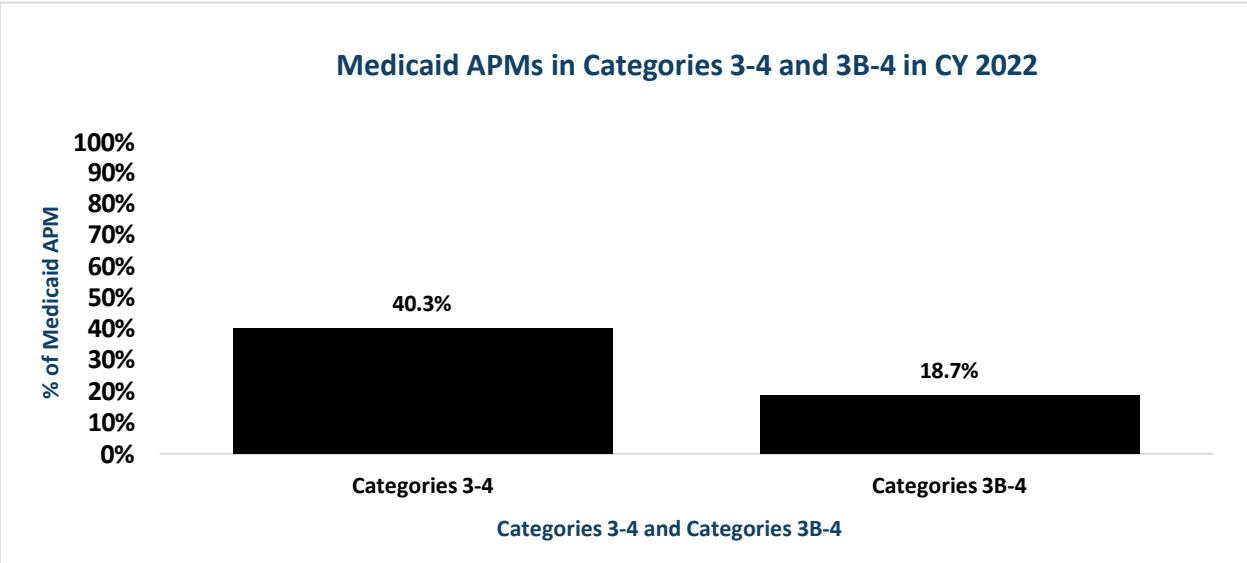


[6] See footnote 2.

Medicaid

The Medicaid data, representing 62.3% of the national Medicaid market (*excluding* enrollees who are dually eligible for Medicare and Medicaid coverage) in 2022[7] shows the following for payments made to providers in CY 2022:

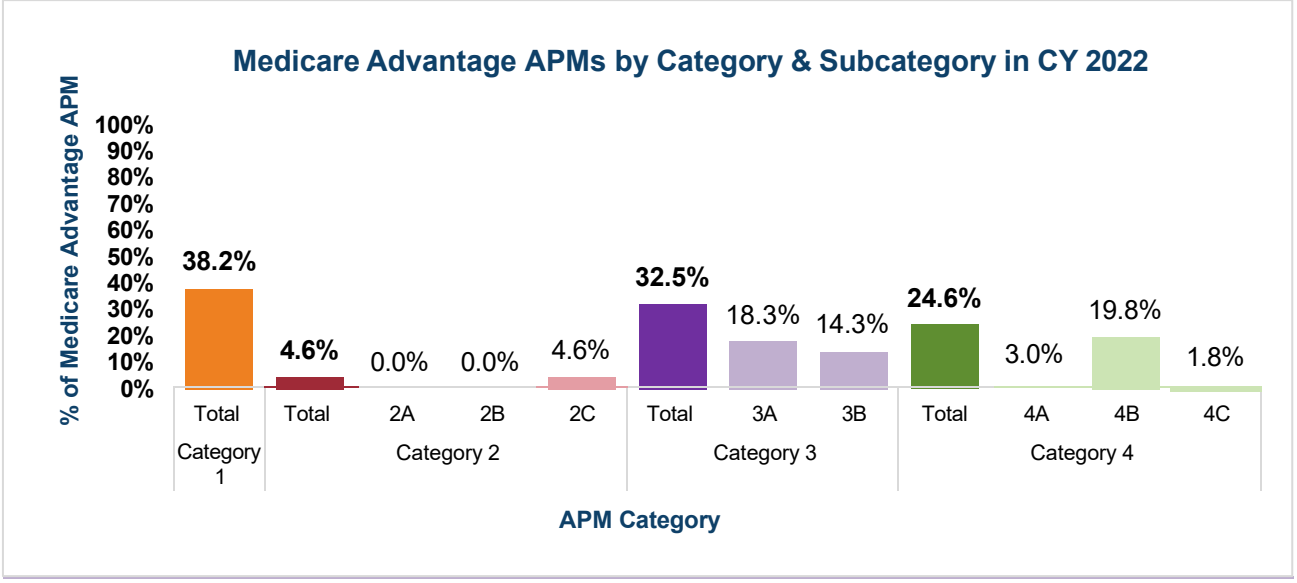


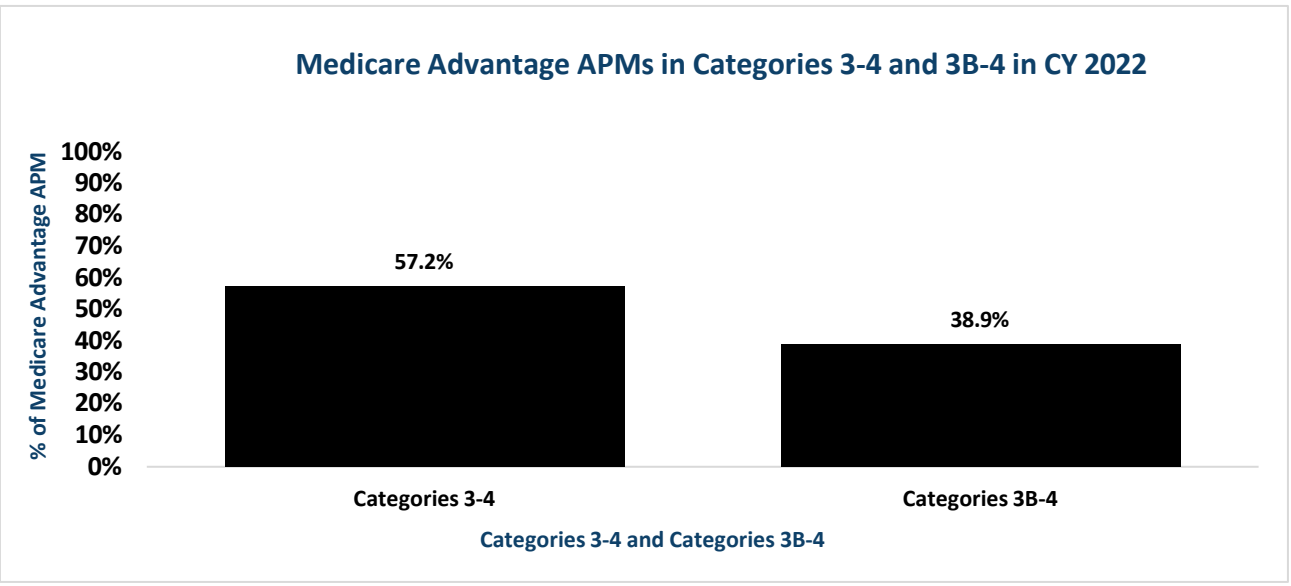


[7] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," March 2023. Available at CMS Fast Facts. Accessed October 11, 2023.

Medicare Advantage

The Medicare Advantage data, representing 68.9% of the national Medicare Advantage market (*including* enrollees who are dually eligible for Medicare and Medicaid coverage) in 2022,[8] shows the following for payments made to providers in CY 2022:

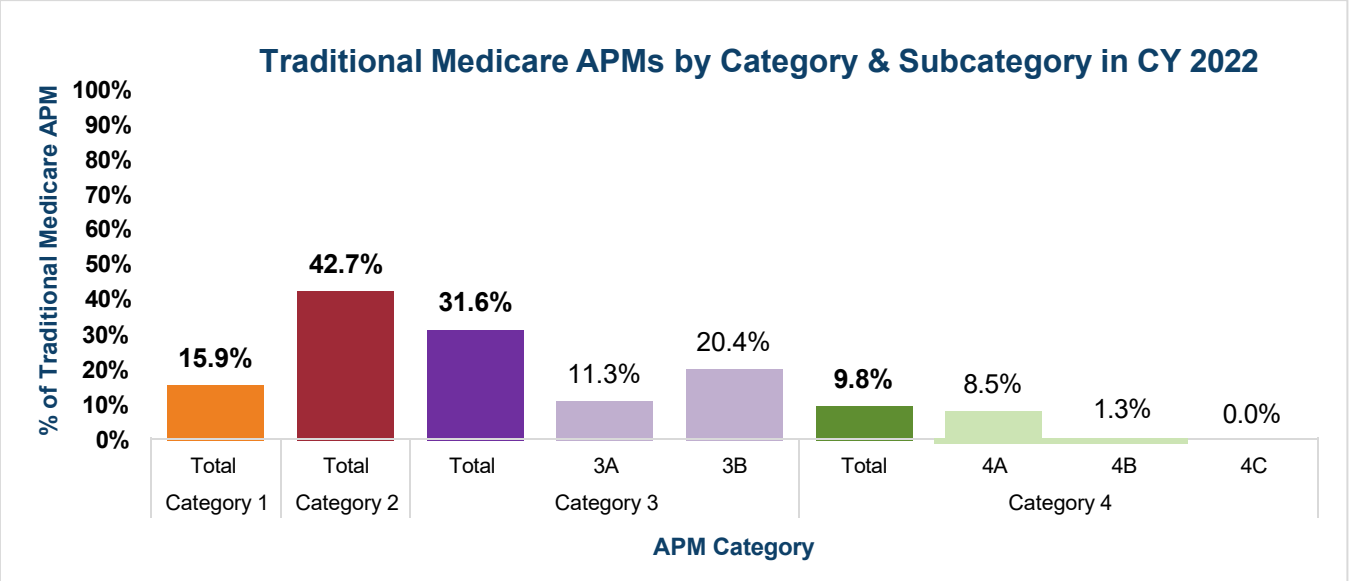


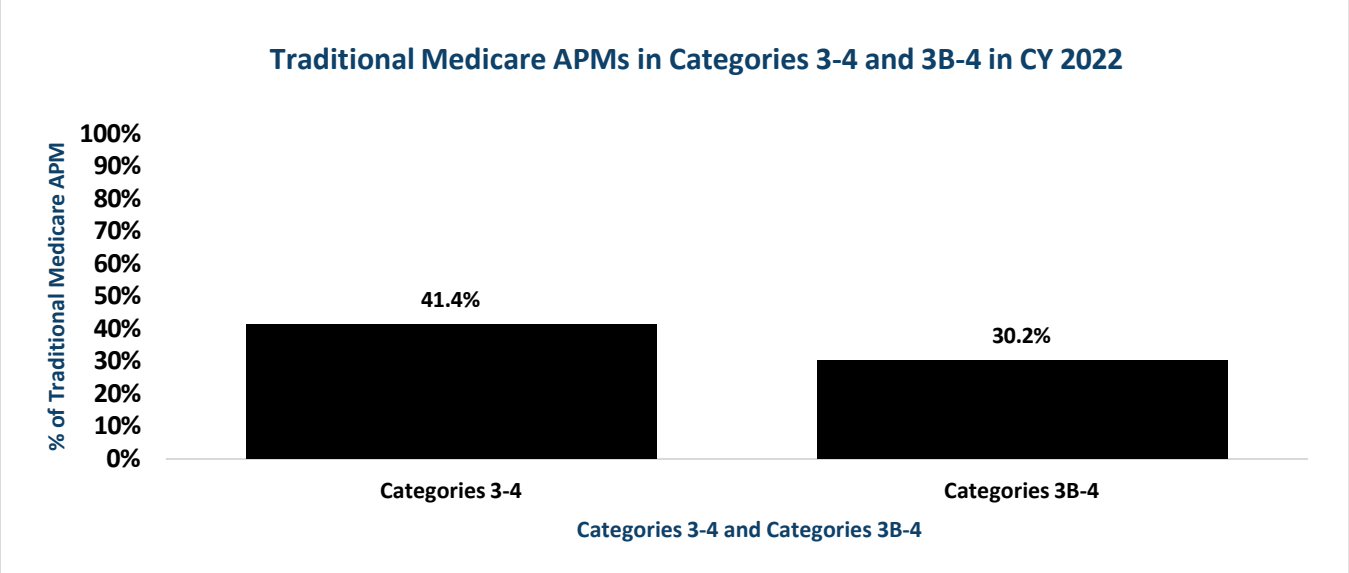


[8] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," March 2023. Available at CMS Fast Facts Accessed October 11, 2023. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," August 2023. Available at MMCO Statistical & Analytic Reports | CMS. Accessed October 11, 2023.

Traditional Medicare

The Traditional Medicare data, representing 35,100,000 Traditional Medicare beneficiaries with Parts A and/or B benefits, which is 100% of the Traditional Medicare market,[9,10] shows the following for payments made to providers in CY 2022:





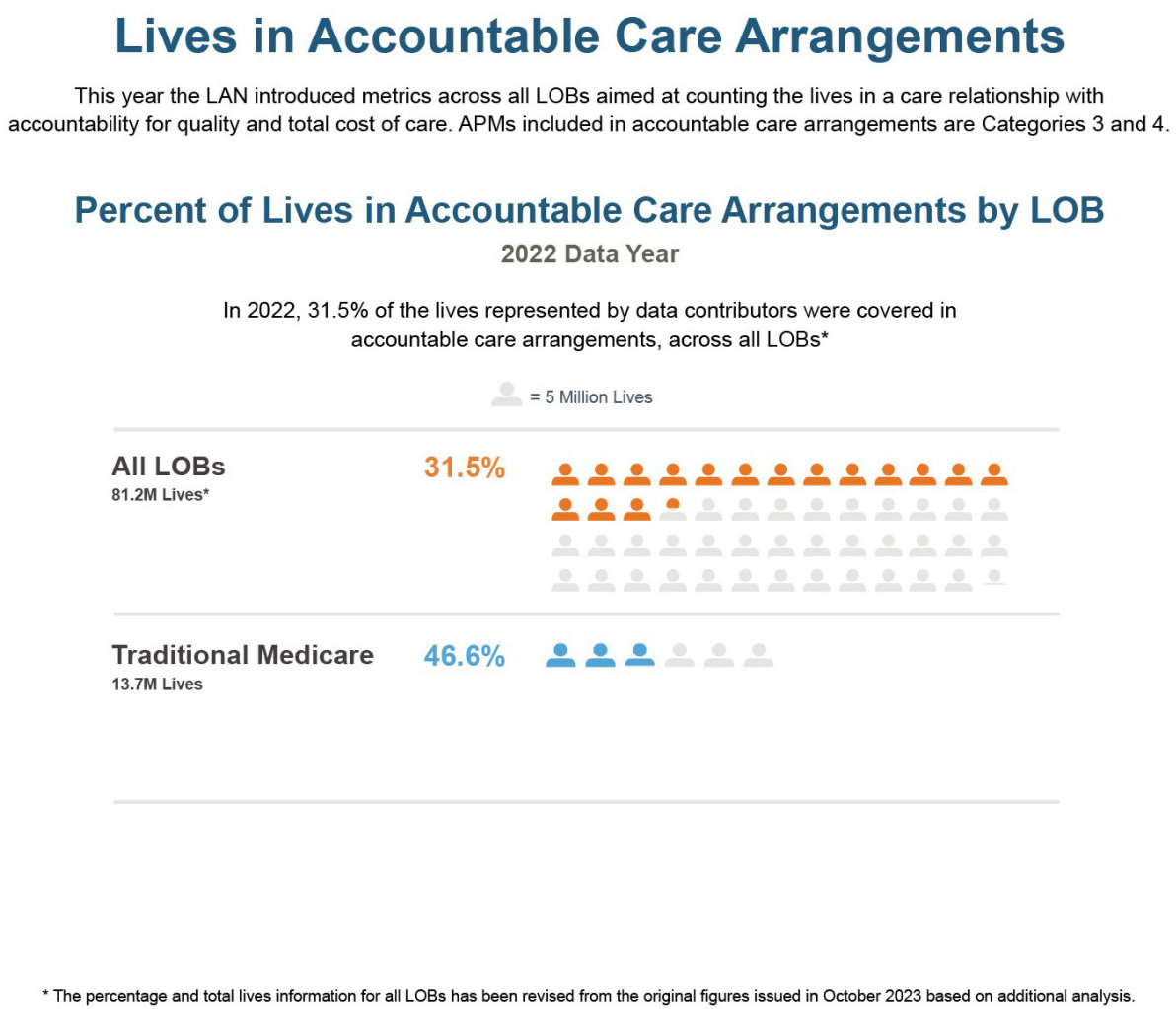
[9] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," March 2023. Available at CMS Fast Facts. Accessed October 11, 2023.

[10] Kidney Care Choice Model expenditure data was excluded from the 2023 APM analysis, but will be included in the 2024 APM data analysis.

Lives in Accountable Care Arrangements in CY 2022

The combined data from the LAN, BCBSA, AHIP, and Traditional Medicare shows the percentage of member lives in accountable care arrangements in CY 2022. In 2022, 31.5%* of the lives represented by data contributors were covered in accountable care arrangements, across all LOBs. This data is displayed in the aggregate by (Commercial, MA Medicaid, and Traditional Medicare) and Traditional Medicare only (Figure 5).[11]

Figure 5: Lives in Accountable Care Arrangements in CY 2022



* The percentage and total lives information for all LOBs has been revised from the original figures issued in October 2023 based on additional analysis.

[11] Partial benefit members were not included in the covered lives analysis.

Informational Questions

The informational questions below capture responses that were aggregated across the LAN, AHIP, and BCBSA surveys. The questions were aimed at collecting data on respondent's opinions of APM activity.

Table 3: Responses to the Informational Questions

INFORMATIONAL QUESTIONS IN 2023 MEASUREMENT SURVEY				
PAYERS WHO THINK APM ACTIVITY:	***WILL INCREASE***	***WILL STAY THE SAME***	***WILL DECREASE***	***PAYERS WHO ARE NOT SURE/DECLINED TO RESPOND***
	72.0%	16.0%	4.0%	7.0%
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)				43.0%
• Traditional shared-savings, Utilization-based shared-savings (3A)				31.0%
TOP THREE BARRIERS TO APM ADOPTION AS IDENTIFIED BY PAYERS				
1. Provider willingness to take on financial risk 2. Provider interest/readiness 3. Provider ability to operationalize				
TOP THREE FACILITATORS TO APM ADOPTION AS IDENTIFIED BY PAYERS				
1. Health plan interest/readiness 2. Provider interest/readiness 3. Provider willingness to take on financial risk				

INFORMATIONAL QUESTIONS IN 2023 MEASUREMENT SURVEY			
PAYER APM PREDICTIONS OF THE FOLLOWING: [12]	***AGREE/ STRONGLY AGREE***	***DISAGREE/ STRONGLY DISAGREE***	***UNSURE/ DID NOT RESPOND***
APM adoption will result in better quality of care	93.0%	3.0%	4.0%
APM adoption will result in more affordable care	79.0%	6.0%	15.0%
APM adoption will result in improved care coordination	93.0%	3.0%	4.0%
APM adoption will result in more consolidation among health care providers	37.0%	37.0%	26.0%
APM adoption will result in higher unit prices for discrete services	4.0%	59.0%	37.0%

[12] 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.

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 86.7% of lives in all market segments in the United States in 2022.[13] 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 is 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 that measure APM adoption.

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 and according to the new 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 2022, which could reflect lower levels of APM adoption.

Data Reporting Challenges: This was the first year the LAN fielded metrics aimed at counting the number of lives in accountable care arrangements. Due to data collection constraints, the LAN was unable to report by line of business. The LAN plans to address these data collection constraints for the 2024 Measurement Effort in order to report by line of business.

[13] See footnote 1.

NOTICE

This technical data was produced for the U. S. Government under Contract Number 75FCMC19D0085/75FCMC21F0001, and is subject to Federal Acquisition Regulation Clause 52.227-14, Rights in Data-General.

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

Appendix A: 2023 APM 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

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)

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.

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, longitudinal care. For the purposes of the LAN's annual survey, accountable care must include two elements or dimensions: 1) the care is longitudinal with a duration of six months or longer; and 2) the payment model incorporates accountability for total cost of care (TCOC) for aligned patients. See TCOC definition and further clarification along with examples below.
Alternative Payment Model (APM)	Health care payment methods that use financial incentives to promote or leverage greater value—including higher quality care at lower costs—for patients, purchasers, payers, and providers. This definition is specific to this exercise. If you are interested in MACRA's definition, please reference MACRA for more details. Refreshed APM Framework White Paper MACRA Website

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.

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 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.

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 2022 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**]

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 2022 or most recent 12 months	Calendar year (CY) 2022 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 is accountable for the care of the patients within the panel. (Adapted from AHRQ, AMA definitions) Also known as paneled or paneling. See also assign/assigned/assignment. Source: AHRQ
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**]

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.

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 2022 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 2022 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**]

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**]

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 2022 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 LAN is operated by Deloitte Consulting LLP, with the LAN Operator work funded by the Centers for Medicare & Medicaid Services 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 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.