Instructions: Fill in the cells that are shaded yellow in this worksheet and in the APM reporting template. For questions on terms see the Definitions tab.

MCO Name & Contact Person/e-mail for questions on APM Report (note reporting time period and if you are using an incurred/date of service approach)	

Alternative Payment Models are health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper (https://hcp-lan.org/groups/apm-refresh-white-paper/). See 'refreshed' APM Framework tab for a summary graphic.

Types of APMs (Subcategories)

Question	LAN APM Category	APM Types - Subcategories		Brief description of type of providers/services involved (e.g. primary care, hospitals, maternity providers, etc.). May include additional APM detail such as noting provider payment arrangements that include multiple APMs or shared savings approaches that have not yet been reconciled.
		Select all that apply by putting an X in column C in each applicable row		
Which types of APM payment models were in effect during any portion of the payment period.	2A		Foundational payments for infrastructure and operations	
	2B		Pay for Reporting	
	2C		Pay for Performance	
	3A		APMs with Shared Savings	
	3B		APMs with Shared Savings and Downside Risk	
	4A		Condition-specific population-based payment	
	4B		Comprehensive population-based payment	
	4C		Integrated Finance & Delivery System	

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

Payment Approach		Provider Payments	Percentage of Provider Payments	
1. Total Annual Provider Payments				
All provider payments	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in specified payment period. Managed Care Incentive Program (MCIP) payments should be excluded from any calculations in this report.	$0	Percentage of Total Provider Payments	#DIV/0!
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
2. Alternative Payment Model Framework - Category 2 (All methods below are linked to quality).				
Category 2A Incentive Payments only (Foundational Payments for Infrastructure & Operations)	**Category 2A APMs ONLY** - Total dollars paid to providers for foundational spending to improve care , e.g. care coordination payments, PCMH payments, infrastructure payments, during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is for foundational spending to improve care.	$0	% of Total provider payments that are paid under Category 2A APMs ONLY	#DIV/0!
Contracts that include Category 2A APMs	**Provider Payments under Contracts that include Category 2A APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** foundational spending to improve care.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A APM	#DIV/0!
		For Provider Contracts with Category 2A APMs - % of provider payments that are linked to foundational payments		#DIV/0!
Category 2B Incentive Payments only (Pay for Reporting)	**Category 2B APMs ONLY** - Total dollars paid to providers for pay for reporting , e.g. payments for reporting on HEDIS measures ('pay-per-click') during payment period. Do not include FFS/base payments, just report the portion of the provider payment that is linked to pay for reporting.	$0	% of Total provider payments that are paid under Category 2B APMs ONLY	#DIV/0!
Contracts that include Category 2B APMs	**Provider Payments under Contracts that include Category 2B APMs** - Total dollars paid under provider contracts that include FFS/base payments **plus** pay for reporting.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2B APM	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated.
For questions on terms see the Definitions tab.

	For Provider Contracts with Category 2B APMs - % of provider payments that are linked to pay for reporting	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Category 2C Incentives only (Rewards for Performance)	**Category 2C APMs ONLY** - Total dollars paid to providers for pay for performance (P4P) rewards to improve care, such as provider performance to population-based target for quality such as a target HEDIS rate. Do not include FFS or base payments to providers. Do not include payments to providers for reporting HEDIS or other measures.	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Category 2C Penalties only (Penalties for Performance)	**Category 2C APMs ONLY** - Total dollars for any penalties applied to providers based on performance to quality measures. Do not include FFS or base payments to providers. Do not include penalties for non-reporting.	$0	% of Total provider payments that are paid under Category 2C APMs ONLY	#DIV/0!
Contracts that include Category 2C APMs	Total dollars paid under provider contracts that include FFS/base payment **plus (or minus)** any P4P payments or penalties, as applicable, (linked to quality) during payment period	$0	% of Total provider payments that are paid under contracts that include at least one Category 2C APM	#DIV/0!
			For Provider Contracts with Category 2C APMs - % of provider payments that are linked to P4P	#DIV/0!

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.				
Payment Approach		**Provider Payments**	**Percentage of Provider Payments**	
Alternative Payment Model Framework - Category 3 (All methods below are linked to quality)				
Category 3 - Only **Shared Savings** Payments to providers	Total **shared savings** dollars ONLY paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are paid out under Category 3 shared savings arrangements	#DIV/0!
Category 3 - Only **Downside Risk** 'recoupments' applied to providers	Total **downside risk** collections or recoupments applied to providers under contracts that include Category 3 APMs and paid on FFS architecture (with links to quality). Do not include FFS or base payments to providers.	$0	% of Total provider payments that are collected or applied to providers under Category 3 shared risk arrangements	#DIV/0!
Contracts that include Category 3 APMs	Total dollars paid to providers under contracts that include Category 3 APMs paid on FFS architecture (with links to quality), include FFS/base payment **plus** any shared savings **or minus** downside risk applied during payment period, as applicable.	$0	% of Total provider payments that are paid under contracts that include at least one Category 3 APM	#DIV/0!
Alternative Payment Model Framework - Category 4 (All methods below are linked to quality)				
Category 4 - Population Based Payments to providers	Total dollars paid to providers for **population-based payments** as part of prospective payment/capitation. For example, PMPM primary care capitaton payments, prospective payments for specialty services, global budgets, and other payments made within prospective capitated arrangements.	$0	% of Total provider payments that are paid under Category 4 APMs	#DIV/0!
Contracts with Category 4 APMs	Total dollars paid to providers under contracts that include **Population-based APMs** (Category 4). Population-based payments include prospective primary care, condition-specific population-based payments, comprehensive population-based payments, and payments made within integrated finance and delivery systems.	$0	% of Total provider payments that are paid under contracts that include Category 4 APMs	#DIV/0!
For calculation only - Contracts with one or more APMs in category 2A, 2C, 3 or 4 (excludes contracts with only Category 2B APMs)				

Instructions: Fill in the cells that are shaded yellow in this worksheet. Other cells in this worksheet will automatically be calculated. For questions on terms see the Definitions tab.					
Automated calculation of payments under provider contract with one or more APMs in categories 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs as reported above. If an MCO reported a contract(s) with more than one APM Categories (e.g., Category 2 and 3) in more than one of the following cells: C8, C15, C21 or C23, this total it will be "**overstated."**	$0			
Overstated provider payments in contracts with multiple APMs	In cases of provider contracts that include mulitple APM categories, enter total amount of the overstated provider contract(s) so that no provider contract is counted more than once in cells C8, C15, C21, or C23.	$0			
VBP BENCHMARK (Contracts with one or more APMs in category 2A, 2C, 3 or 4)					
Total Provider Incentive Payment Payments in Category 2A, 2C, 3 and 4	Total dollars paid to providers during the payment period within Categories 2A, 2C, 3 and 4, counting downside risk and penalties as positive numbers.	$0	% of Total provider incentive payments paid under Category 2A, 2C, 3 or 4 APMs		**#DIV/0!**
Contracts that include Category 2A, 2C, 3 or 4 APMs (unduplicated)	Total dollars paid to providers during the payment period under contracts that include Category 2A, 2C, 3 or 4 APMs (all with links to quality). This may be less than the combination of provider contract payments reported under each applicable LAN category as calculated in cell C25. If a contract includes more than one type of APM, it should only be counted once in the VBP benchmark.	$0	% of Total provider payments that are paid under contracts that include at least one Category 2A, 2C, 3 or 4 APM		**#DIV/0!**

Definitions

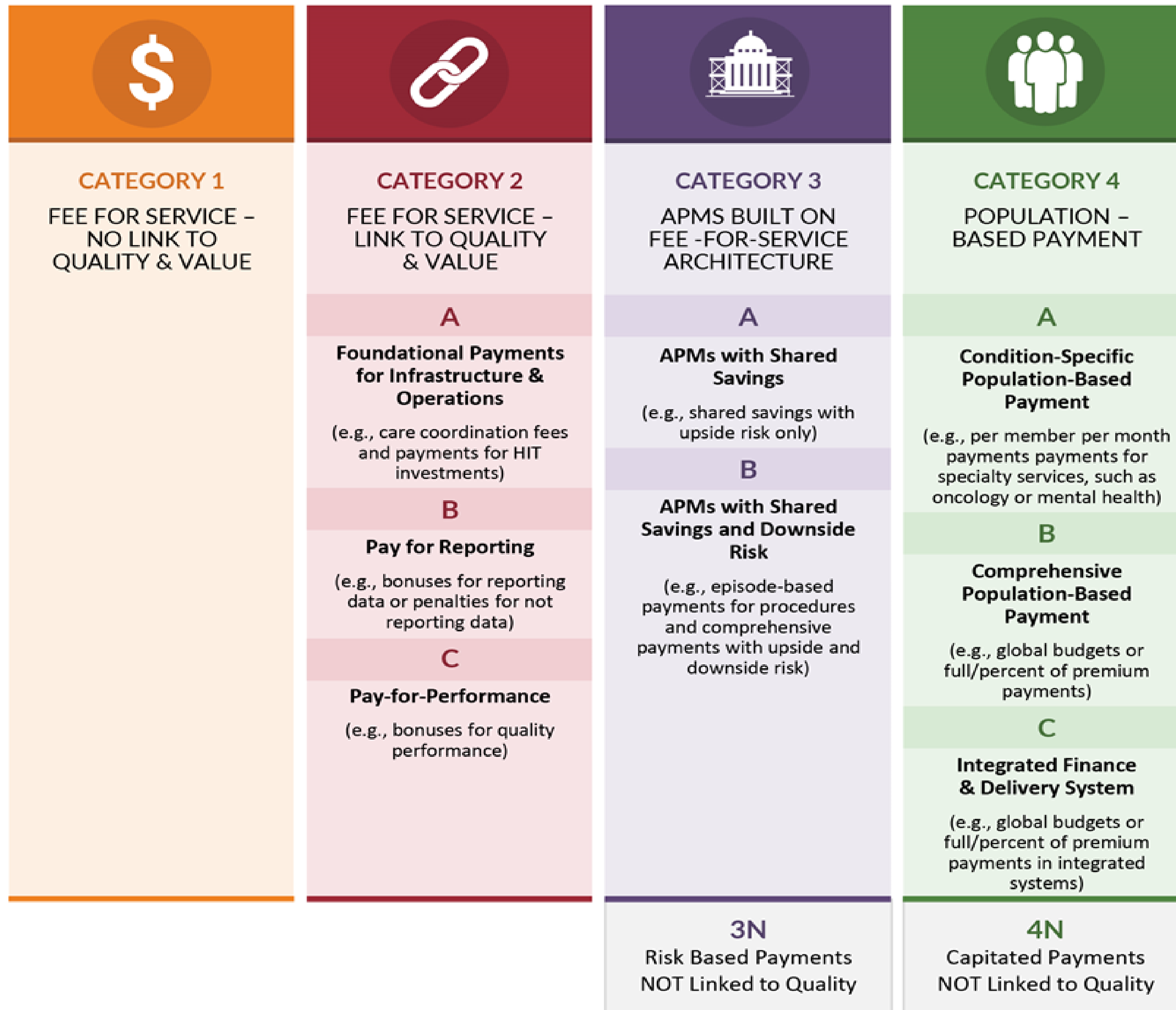
Terms	Definitions
Alternative Payment Model (APM)	Health care payment methods at the provider level that use financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. The APM framework categories are based on the definitions in the Health Care Payment Learning Action Network (LAN) and articulated in the APM Framework White Paper and the graphic included on the 'refreshed' APM Framework tab. https://hcp-lan.org/groups/apm-refresh-white-paper/
Category 2 APM (must be linked to quality)	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. Examples are described in more detail in other definitions and include: 2A: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for HIT investments 2B: Pay for Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems 2C: Rewards and Penalties for Performance: Bonus payments/rewards and/or penalties for quality performance on specified measures, including those in DRG systems.
Category 3 APM (excludes risk-based payment models that are NOT linked to quality)	Alternative payment methods (APMs) built on **fee-for-service architecture** while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are **based on cost performance against a target**, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are retrospectively eligible for shared savings, and those that do not may be held financially accountable. Examples include: 3A: APMs with upside gain sharing based on a budget target/shared savings: retrospective bundled payments with upside risk only, retrospective episode-based payments with shared savings (no shared risk); PCMH with retrospective shared savings (no shared risk); Oncology COE with retrospective shared savings (no shared risk). 3B: APMs with upside gain sharing and downside risk: retrospective bundled payments with up and downside risk, retrospective episode-based payments with shared savings and losses; PCMH with retrospective shared savings and losses; Oncology COE with retrospective shared savings and losses.

Definitions

Terms	Definitions
Category 4 APM (excludes capitated payment models that are NOT linked to quality)	**Prospective population-based payment**. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined or overall budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Examples include: 4A: Condition-specific population-based payments, e.g. via an ACO, PCMH or Center of Excellence (COE), partial population-based payments for primary care, and episode-based payments for clinical conditions such as diabetes. 4B: Comprehensive population-based payments - full or % of premium population-based payment, e.g. via an ACO, PCMH or Center of Excellence (COE), integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care. 4C: Integrated Finance & Delivery Systems - global budgets or full/percent of premium payments in integrated systems
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]**
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency. [APM Framework Category **1**]
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** if there is a link to quality**]**
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 a quality standard(s) or improve care or clinical services, including for providers who report quality data, or providers who meet thresholds on cost and quality metrics.

Definitions

Terms	Definitions
Pay for performance	The use of financial incentives 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. [APM Framework Category **2C** if there is a link to quality].
Payment Period	The twelve month period, applicable to the specified MCO reporting requirements.
Population-based payment for conditions	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period including inpatient care and facility fees. [APM Framework Category **4A** if there is a link to quality].
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could be, for example, primary care services or professional services that are not specific to any particular condition. [APM Framework Category **3B** if there is a link to quality].
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g. hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3A** & **3B**].
Provider	For the purposes of this report, provider includes all providers for which there is MCO health care spending. For the purposes of reporting APMs, this definition of provider includes medical, behavioral, pharmacy, DME, PCMH/FCMH, dental, vision, transportation, and local health departments (e.g., lead screening) etc. as applicable.
Shared risk/losses	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 meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. Shared savings provides an upside only financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care and to meet quality targets.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in the applicable payment period.



Note - This is a draft refreshed framework. The comment period has closed. The LAN may issue clarifications or changes.