CONNECTICUT
Health Strategy

Alternative Payment Model Monitoring: 2022

A report pursuant to C.G.S. 19a-754a

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Commissioner

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Acronym Glossary

ACO	Accountable care organization
APM	Alternative payment model
COE	Center of excellence
DRG	Diagnosis-related group payment
DSS	Department of Social Services
FEHB	Federal Employee Health Benefits
FFS	Fee-for-service
HCP-LAN	Health Care Payment Learning Action Network
LTSS	Long-term services and supports
OHS	Office of Health Strategy
PCG	Primary care group
PCMH	Patient-centered medical home
PCP	Primary care provider
PMPM	Per member per month
TCOC	Total cost of care

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Executive Summary

Connecticut General Statutes (C.G.S.) § 19a-754a charges the Office of Health Strategy (OHS) with monitoring the adoption of alternative payment methodologies (APMs) in the state.

The term "alternative payment model" (or "APM") encompasses a diverse array of payment structures, including pay-for-performance incentives, bundled payments, capitation, shared savings, and global budgets, each varying in their focus and degrees of shared risk and accountability.

The context for this report is rooted in Connecticut's unique position as a high healthcare cost state and in the vanguard among a number of states undertaking healthcare benchmarking to address costs, quality and primary care.

Despite our state's high healthcare expenditures, our residents experience delays, shortages and disparities. Connecticut has a severe shortage of primary care providers, which is expected to continue[1]. In fact, more than 500,000 individuals live in designated health professional shortage areas.[2] Racial/ethnic disparity in access to primary care providers is a particular problem. For instance, more than one in four Latine/Hispanic adults do not have a personal doctor as compared to white adults, for whom the rate is about one in 10.[3]

Connecticut residents face inpatient prices that are not only higher than many other comparable areas in New England but also far beyond the national median. In 2021, hospital inpatient prices in Hartford were 27% greater, New Haven 42% greater, and

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[1] Connecticut Department of Public Health. Connecticut Primary Care Assessment A Preliminary Needs Assessment Scan of the Primary Healthcare Sector.(2021, December) https://portal.ct.gov/-/media/dph/primary-care-office/pcna-finaldraft-v8_122821revised.pdf

[2] KFF. State Health Facts. Primary Care Health Professional Shortage Areas. (2024, April 1) https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] Levin, A. (2020, January) Health Disparities in Connecticut: Causes, Effects, and What We Can Do. https://www.cthealth.org/wp-content/uploads/2020/01/Health-disparities-in-Connecticut.pdf

Bridgeport 43% greater than the national median for inpatient hospital prices in US metro areas.[4]

Connecticut's three healthcare benchmarks (Cost-Growth, Quality, and Primary Care) were established to tackle these issues and act as both guardrails and guideposts to strengthen Connecticut's primary care infrastructure, improve quality and equity in our healthcare system, and manage rising costs. The benchmarks initiative has created a framework to support further exploration and evaluation of promising models to address healthcare affordability within the state.

APMs may offer an important strategy for achieving the goals of improving healthcare quality and outcomes while controlling costs. Assessment of various types of APMs, including models used by Accountable Care Organizations (ACOs), have shown mixed results to date, however the shift to patient-first, or value-based care, has shown enough promise to merit further monitoring.

The historically predominant fee-for-service payment structure in the United States has resulted in the highest cost healthcare system among developed nations, yet one that produces health outcomes and life expectancy that lag behind other industrialized countries.[5] By shifting from volume-based reimbursements to value-based payments, APMs aim to re-orient our healthcare financing structures to support quality outcome measures. APMs shift the healthcare system's focus away from the quantity of services provided to the overall well-being of patients.

This report assesses APM adoption in Connecticut using the Healthcare Payment Learning and Action Network (HCP-LAN)'s classification system, which offers a common framework for classifying and designing alternative payment models. HCP-LAN is a nonprofit alliance of healthcare experts that promotes shared accountability in the healthcare system. HCP-LAN classifies APMs into four different categories

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[4] HMI Interactive Report. (2017). Health Care Cost Institute. https://healthcostinstitute.org/hccioriginals/hmi-interactive

[5] Schneider, E. C., Shah, A., Doty, M. M., Tikkanen, R., Fields, K., & Williams, R. D. (2021, August 4). *Mirror, mirror: Comparing Health Systems across countries*. Commonwealth Fund. https://www.commonwealthfund.org/series/mirror-mirror-comparing-health-systems-across-countries

based on the extent to which payments reward value of services rather than volume of services.

Some APMs such as those with downside risk and population-based payments (i.e., Category 3B and Category 4 APMs, see below) can increase savings and quality outcomes. [6,7,8,9] Studies of commercial and public APMS, including the Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts' ACO program and Maryland's hospital global budget program have demonstrated improvements in quality, as well as savings or slowed cost growth. Medicare's Shared Savings Program, physician-led ACOs (compared with hospital-integrated ACOs) achieved modest savings in total spending.[10]

APMs represent a promising pathway to explore to reduce healthcare costs, improve quality, and emphasize primary care and health equity. More than half (54.6%) of CY 2022 healthcare payments fell within a Category 2, 3 or 4 model on the HCP-LAN scale, including categories that retain a fee-for-service foundation.

Category #	Category Description
Category 1	Fee for Service (FFS) not linked to quality
Category 2	FFS linked to quality and value
▪ Category 2A	Foundational Payments for Infrastructure and Operations
▪ Category 2B	Pay-for-Reporting

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[6] Song, Z., Safran, D. G., Landon, B. E., He, Y., Mechanic, R. E., Day, M. P., & Chernew, M. E. (2019). Health care spending, utilization, and quality 8 years into global payment. *The New England Journal of Medicine, 381*. Accessed February 23, 2024.

[7] McWilliams, J. M., Hatfield, L. A., Chernew, M. E., Landon, B. E., & Schwartz, A. L. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. *The New England Journal of Medicine, 379*. Accessed February 23, 2024.

[8] Centers for Medicare & Medicaid Services. (2020). *Maryland All-Payer Model: Final evaluation report*. https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf.

[9] Lowell, K. H. (2020). *Third evaluation report: Next Generation Accountable Care Organization Model Evaluation*. NORC. Accessed February 23, 2024.

[10] McWilliams, J. M., Hatfield, L. A., Chernew, M. E., Landon, B. E., & Schwartz, A. L. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. *The New England Journal of Medicine, 379*. Accessed February 23, 2024.

▪ Category 2C	Pay-for-Performance
Category 3	Alternative payment models built on fee-for-service architecture
▪ Category 3A	Upside gain sharing
▪ Category 3B	Upside gain sharing and downside risk
Category 4	Population-based payments
▪ Category 4A	Condition-specific population-based payments
▪ Category 4B	Comprehensive population-based payments
▪ Category 4B	Integrated Finance and Delivery System

This inaugural report finds that overall APM adoption in Connecticut has made gains in some categories and shows only modest growth in others.

- In 2022, 45.4% of healthcare payments were fee-for-service payments not linked to quality (Category 1); 10.8% of healthcare payments were fee-for-service payments linked to quality (Category 2); 42.4% of healthcare payments were made APMs linked to fee-for-service architecture and 1.5% of payments were made through population-based models (Category 4) (see **Figure 1**).
- In 2022, 41% of commercial lives in Connecticut were under accountable care arrangements (Categories 3 and 4). For Medicare Advantage, the percentage of covered lives was slightly lower at 33.9%. Overall, 39.7% of commercial and Medicare Advantage covered lives in Connecticut were included in APMs, indicating substantial engagement in value-based care models (see **Figure 3**).
- In 2022, only about 14% of covered lives in the commercial and Medicare Advantage markets were attributed to providers participating in one of the two most advanced APMs (called Category 3B and Category 4 APMs, which strongly emphasize patient-centered care while deterring volume-based care).
- In both the commercial and Medicare Advantage markets, Connecticut had a lower rate of Category 4 APM adoption than the national average.

Connecticut's shift toward APMs including pay-for-performance incentives or upside rewards (i.e., Category 2 and Category 3a APMs) may not yet demonstrate quality improvements or slowed cost-growth due to the types and structures of models in place. Initial adoption of population-based payments may provide more promising data if Connecticut participation in these models continues to advance. ***The comparison to national trends suggests that Connecticut is moving towards population-based payments more slowly than the rest of the country, and opportunity exists to increase APM adoption in the state***.[11]

To that end, OHS:

1. encourages large providers and payers to expand participation in evidence-based alternative payment models that emphasize quality, efficiency and affordability;
2. will continue to monitor and report on APM adoption to better assess how APM adoption impacts healthcare affordability, quality, equity, and primary care; and
3. will collaborate with stakeholders to ensure successful implementation and ongoing improvement of value-based care initiatives.

[11] Health Care Payment Learning and Action Network. (2023). *2023 APM measurement*. Retrieved May 17, 2024, from https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/.

Introduction

Both the nation's and our state's healthcare systems are built on a historical fee-for-service structure which pays clinicians based on the volume of services they provide. This ubiquitous payment system has implications for cost, access, equity, affordability and quality:

- Per person health expenditures in the U.S. were $12,555 in 2022, which was over $4,000 more than any other high-income nation. The average amount spent on healthcare per person in comparable countries ($6,651) is about half of what the U.S. spends per person.[12]
- Connecticut residents face inpatient prices that are not only higher than many other comparable areas in New England but also far beyond the national median. In 2021, hospital inpatient prices in Hartford were 27% greater, New Haven 42% greater, and Bridgeport 43% greater than the national median for inpatient hospital prices in US metro areas.[13]

Healthcare costs are straining the state economy and household budgets:

- From 2000 to 2020, per person spending on healthcare in Connecticut grew at an average rate of 4.8% per year, compromising residents' ability to afford critical healthcare services and other basic needs.[14]
- Health insurance costs are a major concern for state businesses, with 24% of small businesses and 18% of large businesses citing it as a critical issue.[15] More

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[12] Emma Wager, Matthew McGough, Shameek Rakshit, Krutika Amin, and Cynthia Cox. (2024, January 23) How does health spending in the U.S. compare to other countries? KFF. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202022%20(U.S.%20dollars,%20PPP%20adjusted)

[13] HMI Interactive Report. (2017). Health Care Cost Institute. https://healthcostinstitute.org/hccioriginals/hmi-interactive

[14] Health Care Expenditures per Capita by State of Residence. (n.d.). KFF. from https://www.kff.org/other/state-indicator/health-spending-per-capita/

[15] Connecticut Business and Industry Association. (2024) *2024 Survey of Connecticut Businesses, available at* https://www.cbia.com/wp-content/uploads/2024/09/2024-Survey-of-Connecticut-Businesses.pdf

than half of Connecticut businesses (53%) indicated that they are not satisfied with the quality and cost of healthcare and insurance.

Despite the higher cost of healthcare, Connecticut residents experience health disparities, shortages, delays and few if any improvements in quality outcomes:

- In the 12 months prior to the October 2022 Consumer Healthcare Experience State Survey by Altarum Healthcare Value Hub, 51 percent of Connecticut residents with commercial coverage went without care due to costs.
- Affordability was problematic for commercially insured residents with a disability and residents of color. Sixty seven percent of disabled residents went without care while 57 percent and 55 percent of Black and Hispanic residents respectively went without care due to costs.[16]
- There is a national and state shortage of physicians, particularly in primary care and in some specialties.[17] Connecticut has a severe shortage of primary care providers, which is expected to continue[18]. In fact, more than 500,000 individuals live in designated health professional shortage areas.[19] Racial/ethnic disparity in access to primary care providers is a particular problem. For instance, more than one in four Latine/Hispanic adults do not

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[16] Healthcare Value Hub. (2022, October). Connecticut Residents Struggle to Afford High Healthcare Costs; Worry about Affording Healthcare in the Future; Support Government Action across Party Lines. Altarum. https://www.healthcarevaluehub.org/advocate-resources/publications/connecticut-residents-struggle-afford-high-healthcare-costs-worry-about-affording-healthcare-future-support-government-action-ac

[17] Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. (2024, March). https://www.aamc.org/media/75236/download?attachment.

[18] Connecticut Department of Public Health. Connecticut Primary Care Assessment A Preliminary Needs Assessment Scan of the Primary Healthcare Sector.(2021, December) https://portal.ct.gov/-/media/dph/primary-care-office/pcna-finaldraft-v8_122821revised.pdf

[19] KFF. State Health Facts. Primary Care Health Professional Shortage Areas. (2024, April 1) https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

have a personal doctor as compared to white adults, for whom the rate is about one in 10.[20]

- Wait times for a primary care and other medical visit are up in the U.S., and anecdotal evidence suggests this is true for Connecticut as well[21],[22] – in part due to health professional shortages. Nationally, the average wait time for a physician appointment in 2022 is 26 days, up from 20.9 days in 2004.[23]
- Compared to their white counterparts, Black and Hispanic Connecticut residents are more likely to live in poorer health and, for Black residents, to die younger.[24]

Connecticut's steadily rising healthcare costs are not resulting in corresponding improvements to quality and patient outcomes.[25] For example, longitudinal (2016-2022) quality indicators for commercially insured people in Connecticut[26] (including the asthma medication ratio, diabetes poor control and controlling high blood pressure, pediatric well care visits, follow up after ED visits and hospitalization for

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[20] Levin, A. (2020, January) Health Disparities in Connecticut: Causes, Effects, and What We Can Do. https://www.cthealth.org/wp-content/uploads/2020/01/Health-disparities-in-Connecticut.pdf

[21] Backus, L. (2024, July 28) How CT health systems are addressing doctor shortage that's impacting patient wait times. CT Insider. https://www.ctinsider.com/news/article/ct-doctor-shortage-hartford-healthcare-yale-19511145.php

[22] Srinivasan, S. (2023, August 18) Wait times for primary care physicians are expected to get longer, but technology may help. CT Public Radio. https://www.ctpublic.org/news/2023-08-18/wait-times-for-primary-care-physician-are-expected-to-get-worse-but-technology-might-be-able-help

[23] AMN/Merritt Hawkins. (2022) 2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates. https://www.amnhealthcare.com/amn-insights/physician/whitepapers/survey-of-physician-appointment-wait-times/

[24] Levin Becker, A. (2022, March) Health Disparities in Connecticut: Causes, Effects, and What We Can Do. https://www.cthealth.org/wp-content/uploads/2020/01/Health-disparities-in-Connecticut.pdf

[25] Connecticut Office of Health Strategy. (2024, May 13) Quality Benchmark Initiative 2022 Performance. https://portal.ct.gov/das/-/media/ohs-beta/pdf/healthcare-benchmarks-unit/ohs--benchmark-report-py2022.pdf

[26] Bailit, M. (May 16, 2024) Quality Council: Longitudinal Quality Benchmark Performance. Connecticut Office of Health Strategy, Quality Council. [Meeting presentation}, Hartford CT, United States. https://portal.ct.gov/ohs/-/media/ohs/quality-council/2024-meetings/05-16-24/ct-ohs-quality-council-meeting-2024-5-16_v2.pdf

mental illness) showed flat performance – with almost no improvements across all indicators mentioned above.

OHS has established healthcare benchmarks (quality benchmarks, a primary spending target and a cost growth benchmark) to address the need to strengthen Connecticut's primary care infrastructure, improve quality and equity in our state's healthcare system, and manage rising costs.

We can achieve these benchmarks by rebalancing our healthcare investments and with comprehensive payment reforms. This requires moving away from paying for volume of services to paying for quality.

The imperative for controlling costs and improving quality also draws from the National Academies of Sciences, Engineering and Medicine[27] recommendations on rebuilding the foundations of the healthcare system and payment reforms.

Volume-based payment models, called fee-for-service (FFS) models, incentivize quantity over quality. Nationwide, there is an ongoing transition to value-based approaches. Value-based care emphasizes the delivery of high-quality care at optimal costs, with the goal of enhancing patient satisfaction, improving population health and equity, and reducing overall healthcare expenditures.

Many states have undertaken efforts to transform primary care, including implementing alternative payment models (APMs), launching patient-centered medical home (PCMH) models, and monitoring primary care investment across public and commercial insurers. There is some evidence that moving towards value-based payments and APMs may improve cost, quality and outcomes.

The effectiveness of APMs[28], and associated improvements in longitudinal healthcare costs, quality and savings depends heavily on program design, contract details and execution. To be effective in reducing healthcare costs, APMs need to offer sufficient financial incentives for outcomes and quality-focused interventions or build out innovative population health strategies. Many APMs take more than a year to

[27] National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. From https://doi.org/10.17226/25983
[28] See footnote 18.

produce results—and yield resources for investment in primary prevention and behavioral health. [29]

Continued monitoring by OHS will provide critical analysis to guide impactful APM adoption in the future. Without change, access to affordable, quality healthcare will decline, impacting the long-term health and well-being of Connecticut residents, particularly in communities with less wealth and less access to care.

APMS[30] have the potential to rebalance Connecticut's healthcare system. APMs seek to align provider incentives with outcome-driven metrics. By contrast, volume-based payment models, called fee-for-service (FFS) models, incentivize quantity over quality. Nationwide, there is an ongoing transition to value-based approaches. Value-based care emphasizes the delivery of high-quality care at optimal costs, with the goal of enhancing patient satisfaction, improving population health and equity, and reducing overall healthcare expenditures.

The Healthcare Payment Learning and Action Network (HCP-LAN), a nonprofit alliance of public and private healthcare experts that has developed a common framework for classifying and designing APMs, measures the annual progress of APM adoption, and promotes shared accountability in the healthcare system. HCP-LAN classifies APMs into four different categories based on the extent to which payments reward value of services rather than volume of services. HCP-LAN's categories are discussed in greater detail later in this report.[31]

Statutory Charge

To address the need to rebalance our healthcare financing system, the Connecticut General Assembly and Governor Lamont enacted Connecticut General Statute §19a-754a(b)(8)(F), which requires OHS to monitor and report on the adoption of payment methodologies in Connecticut. OHS does this by 1) tracking the total dollars paid

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[29] See footnote 18.

[30] The term "alternative payment model" (or "APM") encompasses a diverse array of payment structures, including pay-for-performance incentives, bundled payments, capitation, shared savings, and global budgets, each varying in their focus and degree of provider risk assumption.

[31] Health Care Payment Learning and Action Network. (2017). *Alternative payment model framework*. https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

through APMs and 2) the number of covered lives attributed to providers participating in various types of APMs.

OHS' primary goal in tracking total dollars paid through APMs and lives covered under APMs is to monitor the progress of healthcare organizations in shifting from traditional FFS payment models to more value-based approaches. By tracking and reporting APM payments and covered lives, OHS hopes to contribute to a better understanding of the adoption of these models and help identify areas for improvement and further expansion. This report presents OHS' first annual analysis of statewide APM adoption.

Existing Research

The inherent structure of FFS payment models contributes to higher spending by incentivizing a higher volume of certain services over the quality of care. Other services receive less investment because of the lack of financial incentive. Significant evidence shows that FFS payment models drive spending by increasing the volume and intensity of healthcare services.[32,33] Additionally, some studies indicate that primary care physicians need more time with each patient, which patients also prefer, to discuss patient-specific needs comprehensively.[34,35,36,37]

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[32] Medicare Payment Advisory Commission. (2019). *Report to the Congress: Medicare and the health care delivery system*. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_medpac_reporttocongress_sec-pdf/.

[33] Institute of Medicine. (2013). *Variation in health care spending: Target decision making, not geography*. https://nap.nationalacademies.org/catalog/18393/variation-in-health-care-spending-target-decision-making-not-geography.

[34] Porter, M. E., Pabo, E. A., & Lee, T. H. (2023). Revisiting the time needed to provide adult primary care. *Journal of General Internal Medicine, 38*(1), 147–155. doi:10.1007/s11606-022-07920-2.

[35] Mello, M. M. (2022). Why money is well spent on time. *AMA Journal of Ethics, 24*(12), E1117-1122. doi:10.1001/amajethics.2022.1117. https://journalofethics.ama-assn.org/article/why-money-well-spent-time/2022-12.

[36] Arya, S. (2022). Doctor: EMR or patient time? *AryaEHR*. https://www.aryaehr.com/post/doctor-emr-or-patient-time.

[37] Davis, M. (2020). Time study: How much time do doctors spend on various tasks? *AAFP Family Practice Management Blog*. https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/time-study.html.

APMs provide a promising solution by shifting focus from the quantity of services to the quality and outcomes of care provided. APMs can allow providers to spend more time with each patient without the pressure to see a high volume of patients to maintain revenue. However, evidence of APMs' impact on cost, quality, equity and patient outcomes is both limited and mixed.

Most APM research focuses on accountable care organization (ACO) models. For example:

- The Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts' ACO program, has improved quality and led to savings. It is one of the only large-scale evaluations in the commercial market to date.[38]
    - **Cost**: The increase in the average annual medical spending on claims for the enrollees in organizations that entered the AQC in 2009 was $461 lower per enrollee than spending in the control states, an 11.7% relative savings on claims. Savings on claims were driven in the early years by lower prices and in the later years by lower utilization of services, including use of laboratory testing, certain imaging tests, and emergency department visits.
    - **Quality and outcomes**: Most quality measures of processes and outcomes improved more in the AQC cohorts than they did in New England and the nation in unadjusted analyses.
        - Chronic disease management (e.g., diabetes care) process measures improved from an average of 81% before the initiation of the AQC to 88% after the initiation, whereas New England and national averages were unchanged at 85% and 79%, respectively.
        - Measures for the treatment of depression trended similarly to the New England and national averages, with values generally ranging from approximately 55 to 65%.
        - Adult preventive care measures improved from 62% before the initiation of the AQC to 74% after the initiation. New England and national averages improved from 60% to 63% and 55% to 57%, respectively.

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[38] Song, Z., Safran, D. G., Landon, B. E., He, Y., Mechanic, R. E., Day, M. P., & Chernew, M. E. (2019). Health care spending, utilization, and quality 8 years into global payment. *The New England Journal of Medicine, 381*. Accessed February 23, 2024.

        - Measures of pediatric care in the AQC improved from 83% to 90%, as compared with improved values of 75% to 79% for New England and 64% to 68% nationally.
        - Outcome measures for hypertension and control of glycated hemoglobin among enrollees with diabetes improved from 75% in 2009 to 85% in 2016. Meanwhile, New England and national averages declined slightly.
- Medicare's Shared Savings Program, physician-led ACOs (compared with hospital-integrated ACOs) achieved modest savings in total spending.[39]
    - **Cost and quality**: A 2017 report from the Office of the Inspector General (OIG) found that Medicare Shared Savings Program (MSSP) ACOs generated $1 billion in savings during the first three years of the program. Furthermore, OIG found that MSSP ACOs outperformed fee-for-service providers on the majority (81 percent) of quality measures.[40]
- Maryland's global budget for hospitals (an APM classification) was found to slow total expenditure growth for Medicare beneficiaries by 2.8% relative to the comparison group, largely driven by 4.1% slower growth in total hospital expenditures. For commercial plan members, growth in total expenditures did not abate despite 6.1% slower growth in total hospital expenditures relative to a comparison group.[41]
    - **Quality and outcomes**: Maryland's global budget program had a mixed impact on quality outcomes, with varying results across different measures and populations:
        - Unplanned readmission rates did not change significantly compared to the national average for both Medicare and commercially insured populations, although there was a decline in absolute terms, which was seen nationwide.

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[39] McWilliams, J. M., Hatfield, L. A., Chernew, M. E., Landon, B. E., & Schwartz, A. L. (2018). Medicare spending after 3 years of the Medicare Shared Savings Program. *The New England Journal of Medicine, 379*. Accessed February 23, 2024.

[40] Department of Health and Human Services, Office of Inspector General. (2017). *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality.* https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf.

[41] Centers for Medicare & Medicaid Services. (2020). *Maryland All-Payer Model: Final evaluation report*. https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf.

        - There was a notable decrease in ambulatory care sensitive admissions—6.7% for Maryland Medicare beneficiaries and 6.1% for commercially insured individuals—suggesting successful care management efforts to reduce unnecessary hospitalizations.
        - Visits to the emergency department (ED) within 30 days of discharge declined 5.9% more for commercial plan members compared to the control group.
        - The All-Payer Model had no significant effect on Medicare beneficiaries' avoidable ED visits, except for an 11.2% increase in heart failure-related ED visits.
        - The model had no impact on follow-up visit rates within 14 days post-discharge for Medicare beneficiaries. For commercially insured patients, the percentage of follow-up visits increased, but at a slower rate than in comparison groups.
        - Patient satisfaction in Maryland hospitals was lower than in comparison hospitals across most measures, though it did not decline under the All-Payer Model. Hospitals' efforts to improve patient experience had limited measurable effects.
        - The program was not associated with significant improvements in population health. Although hospitals invested in health initiatives, they struggled to engage patients and influence behavior change.

- The Next Generation ACO program, which had more significant risk sharing, decreased Medicare Parts A and B spending by $1.7 billion relative to the comparison group, but this savings was offset by shared savings and beneficiary incentives (i.e., the amount paid out in quality and savings incentives was greater than the savings achieved). In the final year of the program, after considering shared savings payouts, the model decreased Medicare spending by 2.4%, representing a net reduction of $324.9 million in aggregate.[42]
    - **Quality**: The evaluation of the Next Generation ACO (NGACO) program showed no significant cumulative improvement or decline across three

[42] Lowell, K.H. (2024). *Evaluation of the Next Generation Accountable Care Organization Model. NORC*. Accessed October 8, 2024.

quality measures: hospitalizations for ambulatory care-sensitive conditions (ACSCs), unplanned 30-day hospital readmissions, and readmissions from skilled nursing facilities (SNFs). However, in the final year of the program, unplanned 30-day hospital readmissions decreased by 1.9%, and post-SNF hospitalizations also declined by 1.9%, both statistically significant reductions.[43]

APM Monitoring and Adoption in Other States

Many states have pursued strategies to transition their healthcare markets to APMs, including multi-payer payment reform, target setting or mandates for APM adoption, and APM monitoring and reporting initiatives. A 2019 review of state efforts found that 23 states had established value-based payment targets or mandates, 22 states had adopted or were considering adoption of ACOs or ACO-like entities to help manage costs and deliver better care, and 16 states had adopted or were considering adoption of episodes-of-care programs.[44]

A 2018 review found that at least six states were monitoring APM adoption across their Medicaid, Medicare Advantage and/or commercial markets (Connecticut joins these states with its APM monitoring and reporting initiative).[45]

Specific state examples of APM promotion strategies include:

- **Multi-payer payment reform**: Ohio convened its commercial plans and Medicaid agency to collaborate on a multi-payer delivery system reform initiative that included comprehensive primary care payment and episode-based payments.[46]
- **Target setting**: Oregon has a voluntary compact with more than 40 healthcare organizations committed to "participate in and spread" value-

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[43] Lowell, K.H. (2024). *Evaluation of the Next Generation Accountable Care Organization Model. NORC.* Accessed October 8, 2024.
[44] Change Healthcare. (2019). *Value-based care in America: State by state.* https://thepcc.org/resource/value-based-care-america-state-state.
[45] State Health & Value Strategies. (2018). *State Medicaid approaches for defining and tracking managed care organizations implementation of alternative payment models.* https://www.shvs.org/wp-content/uploads/2018/02/SHVS_APM-Tracking_Brief_Final.pdf.
[46] National Academy for State Health Policy. (2018). *Ohio implements value-based payment reform to improve population health.* https://nashp.org/ohio-implements-value-based-payment-reform-to-improve-population-health/.

based payment with a goal of having 70% of payments be value-based by 2024.[47]

- **Monitoring and reporting**: Massachusetts maintains a standard reporting tool to measure and report the use of APMs by the 10 largest commercial health plans in the state, Medicare Advantage plans, ConnectorCare (the Massachusetts Exchange), Medicaid managed care organizations and the MassHealth Primary Care Clinician Plan.[48]

Connecticut and CMS' States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

In 2024, CMS announced that Connecticut was one of four states selected to participate in a new voluntary, state total cost of care (TCOC) model: the States Advancing All-Payer Health Equity Approaches and Development Model ("States Advancing AHEAD" or "AHEAD" Model). Connecticut will participate in Cohort 2 of the AHEAD model, which would operate from 2024-2034 (with 2027 as the first performance year). The state will receive approximately $12M in federal funding to support model implementation.

The AHEAD Model also offers hospitals and primary care practices new opportunities to participate in innovative components of the total cost of care model:

- **Hospital Global Budgets:** Connecticut hospitals will be offered the opportunity to participate in a global budget payment model that sets a prospective fixed revenue amount for the upcoming year for all payers including Medicare fee-for-service, Medicaid and commercial insurance. This payment structure allows hospitals to have more stable, predictable funding and invest in strategies to enhance care coordination and reduce or eliminate avoidable hospitalizations.

- **Primary Care AHEAD:** Connecticut primary care practices participating in the model will receive a Medicare management fee designed to help advance person-centered care. DSS will align these practices with ongoing Medicaid primary care transformation efforts. Federally qualified health centers will also be eligible to participate.

[47] Oregon Health Leadership Council. (2024). *Oregon value-based payment compact.* https://ohlc.org/partner-initiatives/vbp-compact/.

[48] Massachusetts Center for Health Information and Analysis. *Payer data reporting*: *Total medical expenses (TME) and alternative payment methods (APM).* https://www.chiamass.gov/payer-data-reporting-tme-apm/.

Methodology

OHS collects and analyzes data from insurers on statewide APM adoption. This section provides summary information about OHS' APM data collection and analysis methodology. See the implementation manual posted on OHS' webpage for the detailed APM data specifications.[49]

Data Source

OHS collected 2022 payment and covered lives data from five carriers in the commercial market (Aetna Health and Life ("Aetna"), Anthem Blue Cross and Blue Shield ("Anthem"), Cigna, ConnectiCare and UnitedHealthcare) and four in the Medicare Advantage market (Aetna, Anthem, ConnectiCare, and UnitedHealthcare).

OHS did not collect Medicaid payment data from the Department of Social Services (DSS) for the 2022 payment period but aims to do so for future years of reporting.

APM Categories

OHS uses the HCP-LAN Framework, which categorizes payment models into four major categories based on the degree of financial risk and the potential for care coordination (see **Table 1**). Many insurers are familiar with these categories through the annual HCP-LAN national survey. Additionally, use of this framework allows OHS to compare Connecticut's APM adoption trends to the national trends that HCP-LAN reports.

Table 1. HCP-LAN APM Categories

Category #	Category Description
Category 1 (FFS not linked to quality)	Fee For Service (FFS) payments with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This category also includes diagnosis-related group payments (DRGs) that are not linked to quality.

[49] Connecticut Office of Health Strategy. (2023). *Alternative payment model measurement implementation manual*. https://portal.ct.gov/ohs/pages/guidance-for-payer-and-provider-groups/alternative-payment-model-measurement-implementation-manual.

Category #	Category Description
Category 2 (FFS linked to quality and value)	FFS payments linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are subsequently adjusted for infrastructure investments to improve care or clinical services, based on whether providers report quality data, or based on how well providers perform on certain cost and quality metrics. Examples include: • **Category 2A**: Foundational Payments for Infrastructure and Operations to improve care delivery such as care coordination fees and payments for health information technology investments. • **Category 2B:** Pay-for-Reporting: Bonus payments/rewards for reporting on specified quality measures, including those paid in DRG systems. • **Category 2C**: Pay-for- Performance: Total dollars paid to (or collected from) providers in pay-for-performance APMs.
Category 3 (APMs built on FFS architecture)	APMs built 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 that meet their quality, and cost or utilization targets are eligible to share in savings, and those that do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. Examples include: • **Category 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); patient-centered medical home (PCMH) with retrospective shared savings (no shared risk);

Category #	Category Description
	specialty Center of Excellence (COE) with retrospective shared savings (no shared risk). • **Category 3B:** APMs with upside gain sharing and downside risk (retrospective bundled payments, retrospective episode-based payments, PCMH, specialty COE).
Category 4 (Population-based payments)	Population-based payments. These payments are structured to encourage 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 may 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. Examples include: • **Category 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. • **Category 4B:** Comprehensive population-based payments - full or percentage of premium population-based payment, e.g., via an ACO, PCMH or COE, integrated comprehensive population-based payment and delivery system, comprehensive population-based payment for pediatric or geriatric care. • **Category 4C**: Integrated Finance and Delivery System - move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. e.g., global budgets or fully/percent of premium payments in integrated systems.

Methodological Notes

There are three important methodological considerations to keep in mind when interpreting Connecticut's 2022 APM data:

- **Payment period**: The data reflect the payments made to Connecticut providers during the calendar year (CY) January 1, 2022 – December 31, 2022, or, for contracts that do not follow the calendar year, the most recent 12-month period (i.e., October 1, 2021 – September 30, 2022).
- **Providers participating in multiple APMs**: When providers participated in multiple APMs, payments amounts are allocated to the "highest" category APM. This approach means that dollars reported through a particular category do not indicate the size of any performance incentives, but only the total contract dollars that fall within the category. For example, if a provider had a shared savings contract with a health plan and was also eligible for performance bonuses for meeting quality measure performance targets, the FFS claims, shared savings payments and the pay-for-performance dollars are included in the shared savings category (Category 3).
- **Covered lives**: The covered lives data includes total covered lives for each carrier by market. The covered lives in APMs data represent plan members attributed or assigned to a Connecticut primary care physician (PCP), primary care group (PCG), or a non-PCP (i.e., specialist) participating in an accountable care APM of six months or longer in the calendar year.

2022 APM Adoption and Covered Lives

This section presents 2022 data on (1) APM adoption in Connecticut in the commercial and Medicare Advantage markets, including the percentage of lives attributed to a provider participating in an APM, and (2) compares Connecticut trends to national trends as reported by the HCP-LAN.

Connecticut Commercial Market APM Adoption

During 2022 in the commercial market, nearly half (45.4%) of commercial payments were made through Category 1 models, which are traditional FFS models with no link to quality. A slightly smaller portion (42.4%) of payments were made through Category 3 APMs (i.e., APMs built on FFS architecture, such as shared savings and episode-based payments). Additionally, 10.8% of payments were made through

Category 2 (i.e., FFS payments that included a link to quality, like pay-for-performance or pay-for-reporting incentives). Less than 2% of payments were made through Category 4 (i.e., population-based payment) (see **Figure 1** and **Table 2**)

Figure 1. Percentage of Connecticut Commercial Payments by APM Category during Calendar Year 2022

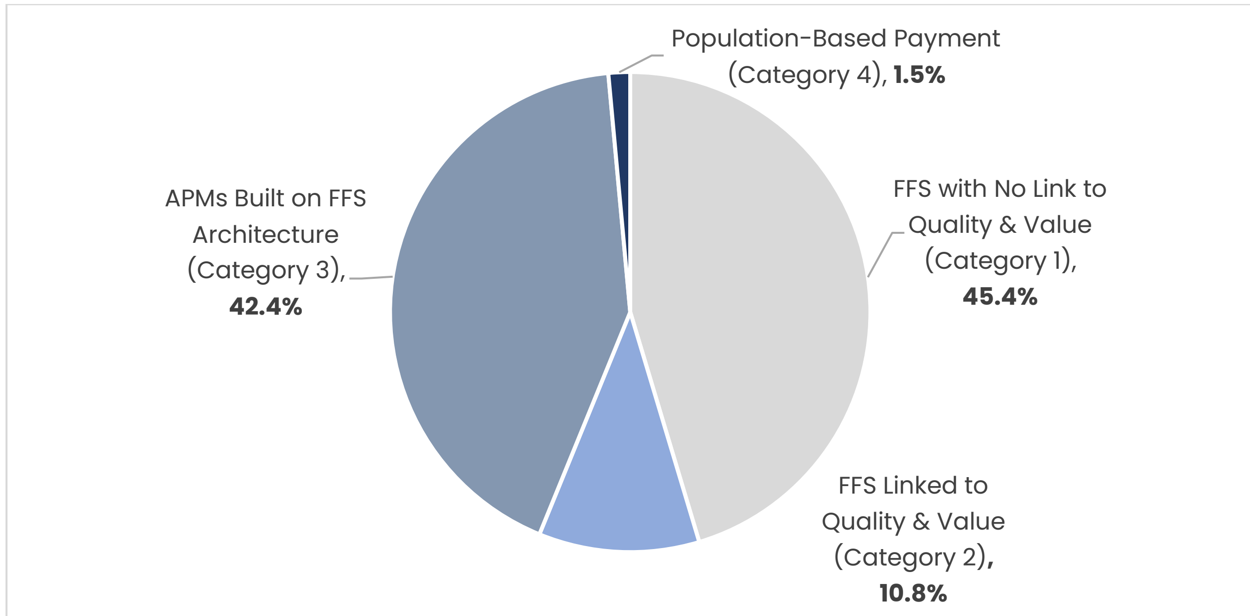


Table 2. 2022 Connecticut Commercial APM Payments by Category and Subcategory during Calendar Year 2022

APM Category #	APM Category Description	CY 2022 Spending	CY 2022 Percent of Total Spending
TOTAL SPENDING		**$11,116,886,683**	**100.0%**
CATEGORY 1 (FFS)		**$5,042,557,435**	**45.4%**
CATEGORY 2 (FFS Linked to Quality & Value)		**$1,202,223,192**	**10.8%**
2A	Foundational spending to improve care	$4,475,353	0.0%
2B	FFS plus pay-for-reporting	$660,294,165	5.9%
2C	FFS plus pay-for-performance	$537,453,674	4.8%
CATEGORY 3 (APMs Built on FFS Architecture)		**$4,709,690,133**	**42.4%**

APM Category #	APM Category Description	CY 2022 Spending	CY 2022 Percent of Total Spending
3A	Traditional shared savings	$2,524,941,293	22.7%
3A	Utilization-based shared savings	$389,508,545	3.5%
3B	FFS-based shared risk	$1,776,401,707	16.0%
3B	Procedure-based bundled/episode payments	$18,838,587	0.2%
CATEGORY 4 (Population-Based Payment)		**$162,415,922**	**1.5%**
4A	Condition-specific population-based payments	$39,789,539	0.4%
4A	Condition-specific bundled/episode payments	$12,006,875	0.1%
4B	Population-based payments that are NOT condition-specific	$110,618,758	1.0%
4B	Full or percent of premium population-based payment	$750	0.0%
4C	Integrated finance and delivery system programs linked to quality	$0	0.0%
Total for CATEGORIES 2, 3 & 4		**$6,074,329,247**	**54.6%**

Medicare Advantage APM Adoption in Connecticut

During 2022 in the Medicare Advantage market, 42.7% of payments were made through Category 1 APMS (traditional FFS with no link to quality), 25.2% through Category 2 (FFS linked to quality and value), 16.3% through Category 3 (APMs built on FFS architecture), and 15.8% through Category 4 (Population-Based Payment) (see **Figure 2** and **Table 3**). This shows a slightly different distribution compared to the commercial market, with a higher emphasis on quality-linked payments and population-based payment models.

Figure 2. Percentage of Connecticut Medicare Advantage Payments by APM Category during Calendar Year 2022

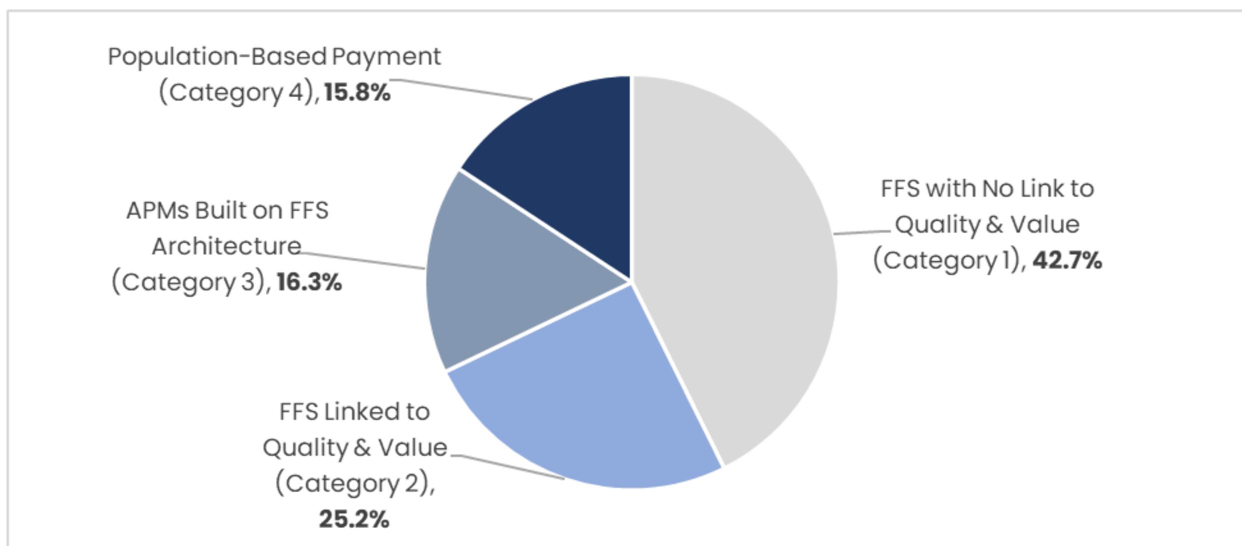


Table 3. 2022 Connecticut Medicare Advantage APM Payments by Category and Subcategory during Calendar Year 2022

APM Category #	APM Category Description	CY 2022 Spending	CY 2022 Percent of Total Spending
TOTAL SPENDING		**$4,393,757,677**	**100.0%**
CATEGORY 1 (FFS)		**$1,874,299,982**	**42.7%**
CATEGORY 2 (FFS Link to Quality & Value)		**$1,109,168,431**	**25.2%**
2A	Foundational spending to improve care	$4,087,716	0.1%
2B	FFS plus pay-for-reporting	$0	0.0%
2C	FFS plus pay-for-performance	$1,105,080,716	25.1%
CATEGORY 3 (APMs Built on FFS Architecture)		**$717,786,631**	**16.3%**
3A	Traditional shared savings	$241,016,131	5.5%
3A	Utilization-based shared savings	$0	0.0%
3B	FFS-based shared risk	$476,770,500	10.8%

APM Category #	APM Category Description	CY 2022 Spending	CY 2022 Percent of Total Spending
3B	Procedure-based bundled/episode payments	$0	0.0%
CATEGORY 4 (Population-Based Payment)		**$692,502,633**	**15.8%**
4A	Condition-specific population-based payments	$151,920,860	3.5%
4A	Condition-specific bundled/episode payments	$0	0.0%
4B	Population-based payments that are NOT condition-specific	$0	0.0%
4B	Full or percent of premium population-based payment	$540,581,773	12.3%
4C	Integrated finance and delivery system programs linked to quality	$0	0.0%
Total for CATEGORIES 2, 3 & 4		**$2,519,457,696**	**57.3%**

Connecticut Lives Covered Under APMs

OHS calculated the lives attributed to providers participating in accountable care arrangements (Categories 3 and 4) for the commercial market, Medicare Advantage market and for both markets combined. In 2022, 41% of commercial lives in Connecticut were under accountable care arrangements (Categories 3 and 4). For Medicare Advantage, the percentage of covered lives was slightly lower at 33.9%. Overall, 39.7% of commercial and Medicare Advantage covered lives in Connecticut were included in APMs, indicating substantial engagement in value-based care models (see **Figure 3**).

However, lives covered in Category 3B and Category 4 APMs (which are more impactful payment models from a cost management perspective) comprised a much smaller percentage of total covered lives in the commercial and Medicare Advantage markets. In 2022, only 14% of commercial lives in Connecticut were

attributed to a PCP or PCG participating in a Category 3B or Category 4 APM. For Medicare Advantage, the percentage was slightly higher at 15.6%. Overall, 14.3% of commercial and Medicare Advantage covered lives were attributed to a PCP or PCG participating in a Category 3B or Category 4 APM (see **Figure 4**).

Figure 3. Calendar Year 2022 Percent of Connecticut Covered Lives Attributed to Providers Participating in Category 3 and 4 APMs

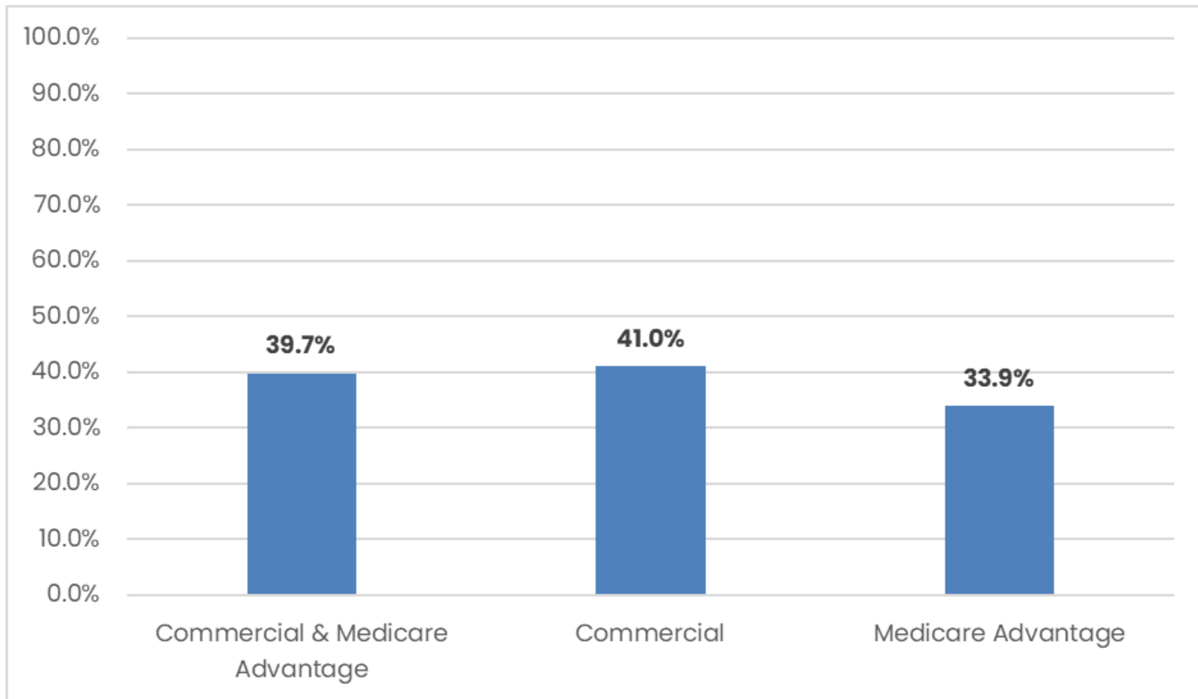
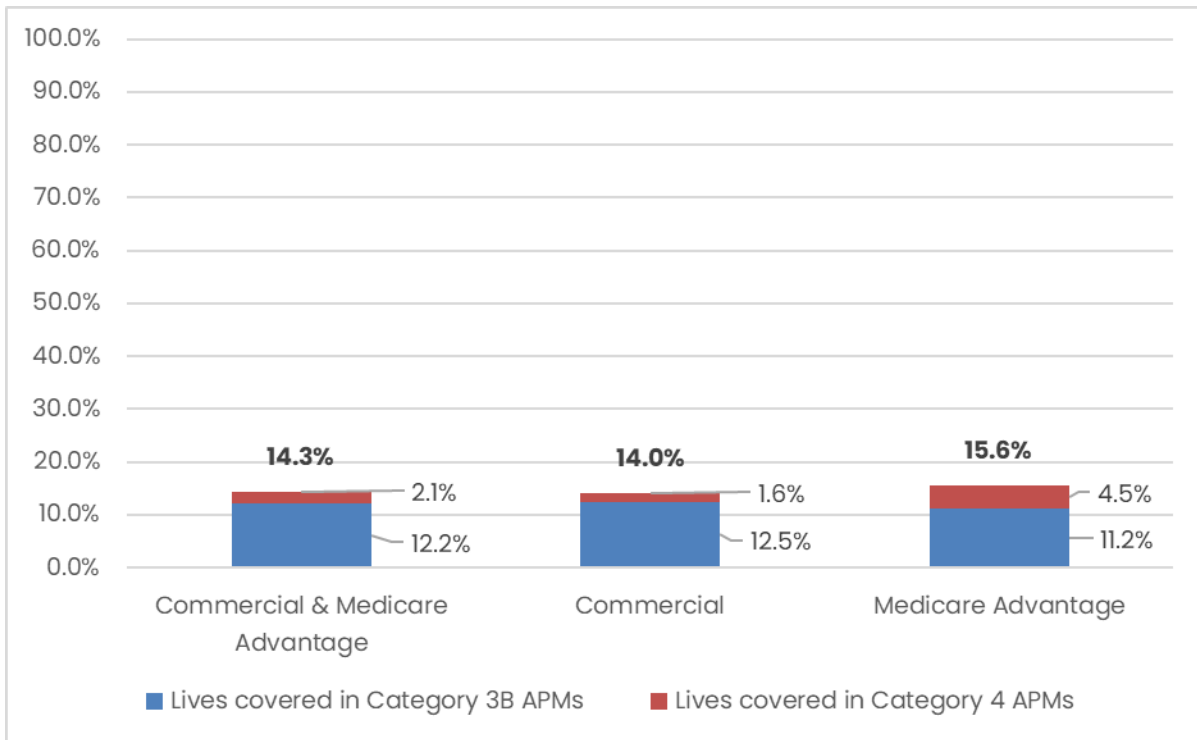


Figure 4. Calendar Year 2022 Percent of Connecticut Covered Lives Attributed to Providers Participating in in Category 3B and 4 (A, B and C combined) APMs (PCG or PCG Attributed Lives Only)



Connecticut Compared to National Trends

OHS compared Connecticut's 2022 APM payments to the HCP-LAN's national survey results.[50,51]

Figure 5 below compares commercial payments in Categories 1-4 in Connecticut and nationally. When compared nationally, within the commercial market, Connecticut had a lower percentage of payments in Category 1 APMs than the national average, and the same percentage of payments in Category 2. Connecticut had a higher percentage of payments made through Category 3 APMs (42.5% in Connecticut compared to 30.6% nationally). Connecticut has a smaller percentage

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[50] Health Care Payment Learning and Action Network. (2023). 2023 APM Measurement. Retrieved May 17, 2024, from https://hcp-lan.org/apm-measurement-effort/2023-apm/2023-infographic/.

[51] HCP-LAN's commercial data represent 69.4% of the commercial market and its Medicare Advantage data represent 78.9% of the Medicare Advantage market.

of payments made through Category 4 APMs as HCP-LAN reported in its national survey (1.5% in Connecticut compared to 4.1% nationally). **Figure 6** below focuses on comparing payments in advanced APMs (Categories 3B and 4) in Connecticut and nationally. Connecticut had a higher percentage of commercial payments made though advanced APMs (i.e., Categories 3B and 4) than HCP-LAN reported in its national survey, but this was driven by Connecticut's higher percentage of Category 3B payments rather than Category 4 payments. **Figure 5. 2022 Connecticut and National Commercial APM Adoption (Categories 1-4)**

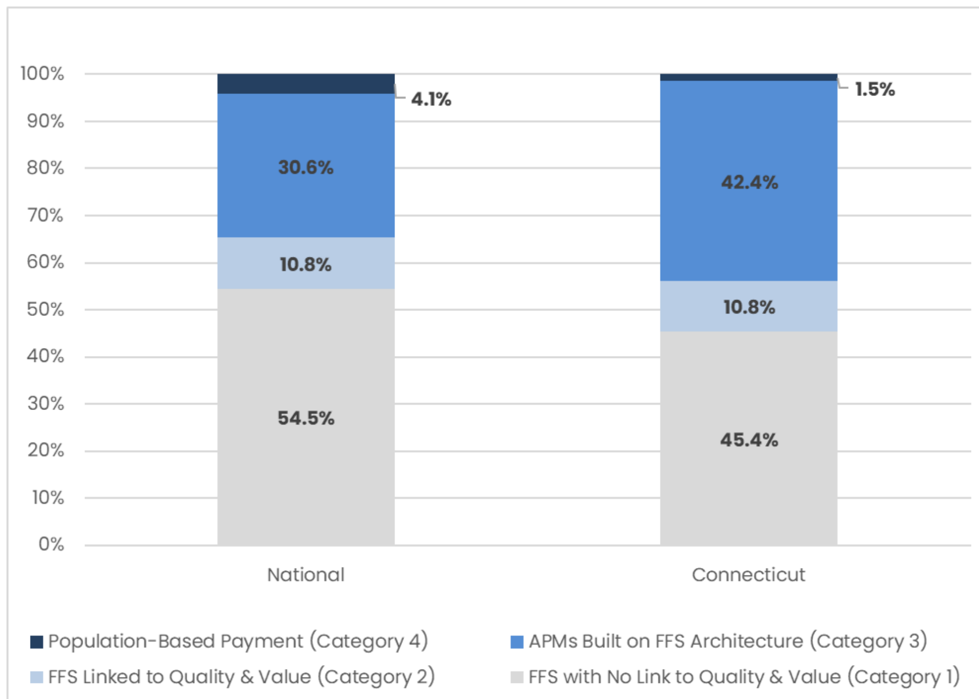
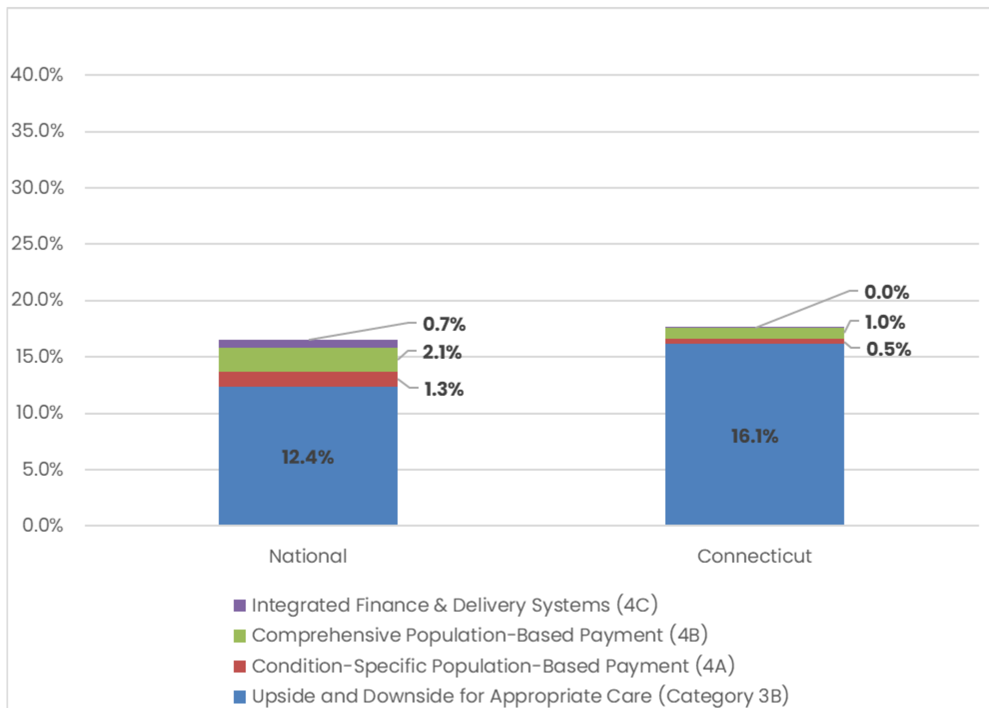


Figure 6. 2022 Connecticut and National Commercial APM Adoption (Categories 3B and 4A, B and C)



In the Medicare Advantage market, Connecticut had a markedly higher percentage of payments made through Category 2 APMs than what HCP-LAN reported in its national survey (25.2% in Connecticut compared to 4.6% nationally). Connecticut had a lower percentage of payments made through Category 3 (16.3% in Connecticut compared to 32.5% nationally) and Category 4 APMs (15.9% in Connecticut compared to 24.6% nationally) (see **Figure 7**). Connecticut had a substantially lower percentage of Medicare Advantages payments made through advanced APMs (Categories 3B and 4) than HCP-LAN reported in its national survey, particularly for Categories 4B (comprehensive population-based payment) and 4C (integrated finance and delivery systems) (see **Figure 8**).

Figure 7. 2022 Connecticut and National Medicare Advantage APM Adoption for Categories 1-4

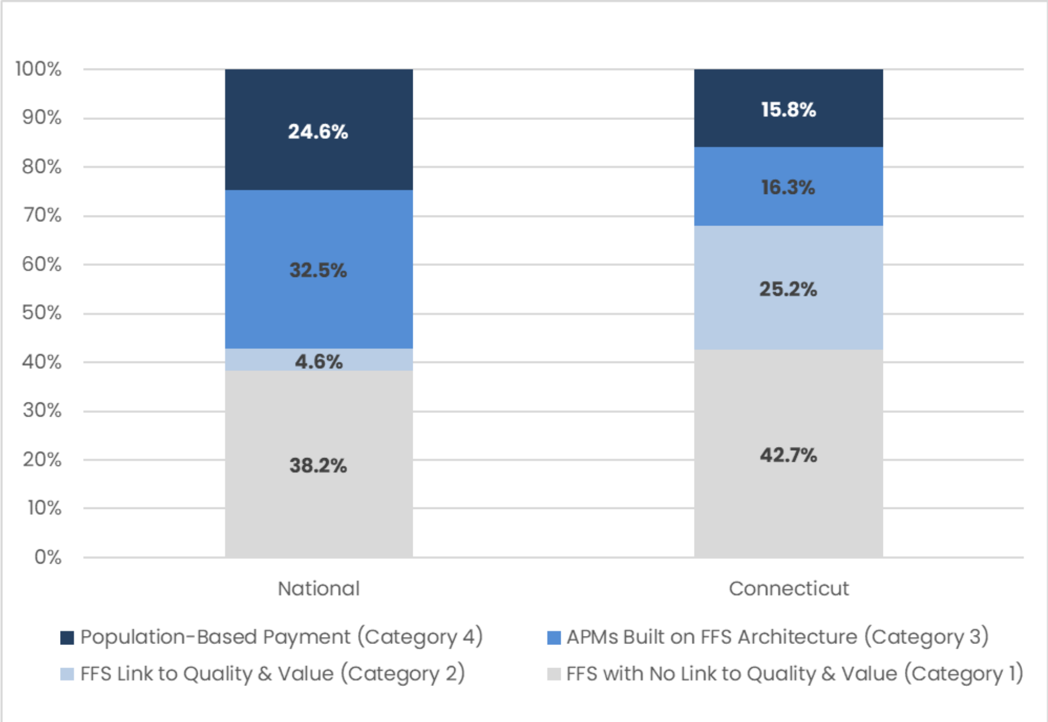
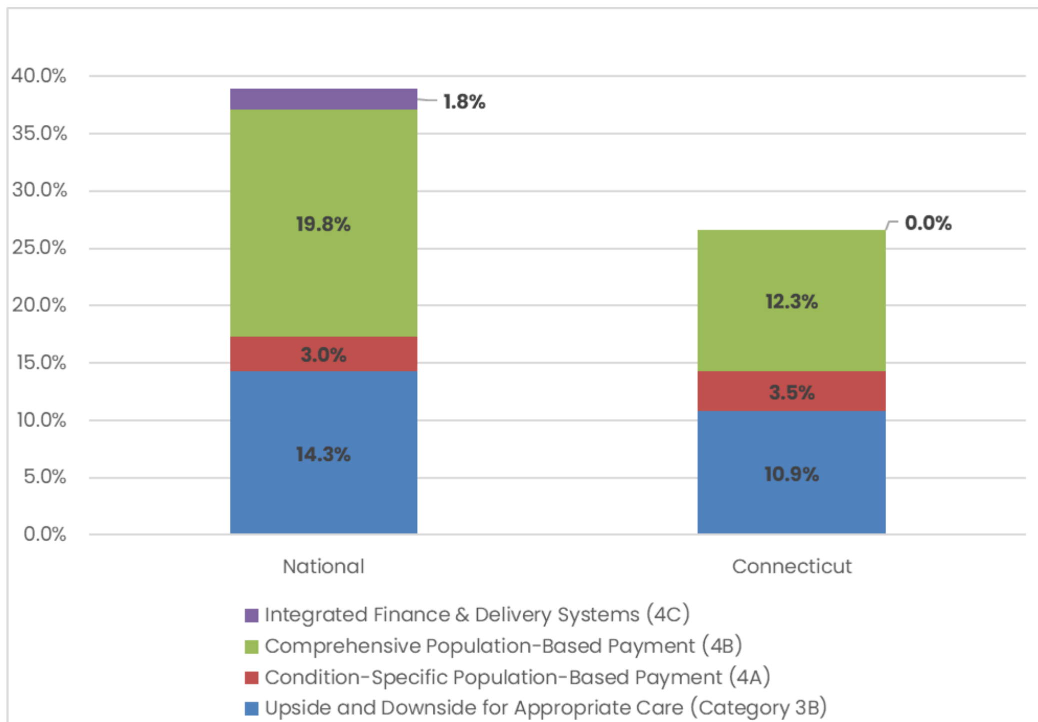


Figure 8. 2022 Connecticut and National Medicare Advantage APM Adoption (Categories 3B and 4 A, B and C)



Conclusion

This section contains a summary of key findings, recommendations, and next steps for OHS’ APM data collection and reporting.

Summary of Key Findings

This analysis of 2022 APMs in Connecticut provides insights into the state's progress towards adopting value-based healthcare payment models. The findings show that:

- **a large percentage of payments are traditional FFS** and there is little adoption of the advanced Category 3B and 4 APMs in both the commercial and Medicare Advantage markets, and
- **Connecticut is further behind national rates of APM adoption for advanced payment models.**
  - In the commercial market in calendar year 2022, nearly half of the payments remain in traditional FFS models, which do not link payment to the quality of care;
  - Less than 20% of commercial spending was in APMs that included downside risk or population-based payment; and
  - Only 14% of commercial lives in Connecticut were attributed to a PCP or PCG participating in an APM that included downside risk or population-based payment.

This indicates a lack of adoption of advanced models, which have the strongest evidence of achieving cost savings and quality improvement. There are signs of commercial market adoption of value-based models, albeit without downside risk. A significant portion of 2022 payments were made through APMs with pay-for-reporting, pay-for-performance quality incentivizes and APMs with upside rewards for appropriate care.

The Medicare Advantage market shows a slightly different distribution, with a lower percentage of payments with upside and downside risk than the commercial market but a more significant portion of payments made through population-based payments.

- The percentage of Medicare Advantage attributed to a PCP or PCG participating in an APM that included downside risk or population-based payment was only slightly higher than the commercial market at 15.6%. This indicates a slightly stronger emphasis on ensuring that payments are tied to

the achievement of quality and cost metrics in the Medicare Advantage market, reflecting a commitment to improving patient care and cost efficiency.

When comparing Connecticut's APM adoption to national trends, the state shows a higher percentage of payments with upside-only or upside and downside risk in the commercial market, but a lower percentage of payments with upside-only or upside and downside risk in the Medicare Advantage market. Connecticut has a lower percentage of payments in APMs with population-based payments in both markets. **This suggests that Connecticut has adopted population-based payments more slowly than the rest of the country.**

Recommendations

There is significant opportunity for Connecticut to further advance APM adoption, particularly the advanced Category 3B and 4 arrangements. Doing so would potentially advance the quality of healthcare services and drive up and primary care investment. These are values that OHS also measures through its annual Cost-Growth, Quality, and Primary Care benchmark initiatives. Importantly, there is wide interest to find alternatives to the current FFS-dominated payment structures.

OHS urges large provider entities to enter Category 3B and 4 arrangements with payers. These advanced payment models hold significant potential for improving patient outcomes by incentivizing high-quality, coordinated care, thereby realizing some of the goals of Connecticut’s healthcare benchmarks. Engaging in Category 3B and 4 arrangements will not only drive better health outcomes but also promote patient affordability and equity by reducing unnecessary spending and optimizing resource utilization. OHS is committed to supporting these efforts through continued monitoring, reporting, and collaboration with stakeholders to ensure successful implementation and ongoing improvement of value-based care initiatives.

Next Steps

OHS will brief legislators and its Healthcare Benchmark Initiative Steering Committee on the findings described in this report. OHS will ask its Steering Committee for its insights and policy recommendations based on the findings.

OHS will collect 2023 APM payment and covered lives data this year and will report on 2022-2023 APM adoption trends in 2025.

OHS will engage with healthcare providers to promote alternative payment models. In fact, Connecticut was one of four states selected to participate in a new voluntary, state total cost of care (TCOC) model: the States Advancing All-Payer Health Equity Approaches and Development Model ("States Advancing AHEAD" or "AHEAD" Model). The AHEAD Model offers hospitals and primary care practices new opportunities to participate in innovative components of the total cost of care model including hospital global budgets. Connecticut primary care practices participating in the model will receive a Medicare management fee designed to help advance person-centered care as well.

Glossary of Key Terms

Accountable care arrangement: An accountable care arrangement is a payment model that incorporates accountability for total cost of care (TCOC) for attributed patients. See TCOC definition and further clarification along with examples below.

Accountable care organization (ACO): An ACO is a group of healthcare providers, such as physicians, hospitals, and other healthcare professionals, that voluntarily come together to provide coordinated, high-quality care to a specific group of patients. The main goals of an ACO are to improve health outcomes, enhance patient experiences, and reduce healthcare cost growth.

Alternative payment model (APM): Healthcare payment models that use financial incentives to promote greater value - including higher quality care, equity and cost efficiency – for patients, purchasers, payers and providers. OHS' APM definitions and categories are based on the Health Care Payment Learning Action Network (HCP-LAN) Framework.

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 preventable or unnecessary procedures. Some examples of appropriate care measures include, but are not limited to potentially avoidable readmissions, potentially preventable admissions, medically unnecessary imaging, and appropriate medication use.

Measures of appropriate care are required 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: 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 provider (PCP) or a primary care group (PCG) for the purposes of an accountable care contract. This term includes a health plan member who chooses (voluntarily, self-designates) a contracted, in-network PCP or PCG or is assigned to a PCP or PCG by the state or plan based on utilization. The PCP or PCG is charged with caring for the patients for whom they have been delegated by the contracted health plan.

Attributed/attribution: Refers to a statistical or administrative methodology that attributes a patient population prospectively or retrospectively to a provider for a particular APM (which must include consideration of cost AND quality). “Attributed” patients 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. The HCP-LAN Framework is agnostic to the attribution method (e.g., prospective or concurrent).

Center of excellence (COE): Specialized programs within healthcare institutions which supply exceptionally high concentrations of expertise and related resources centered on particular medical areas and deliver care in a comprehensive, interdisciplinary fashion.

Commercial market: For the purposes of this report, the commercial market 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 Benefits (FEHB) program, state active employee programs, and/or an exchange, this business is considered commercial

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 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 prospective 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 period, such as a month or year, including inpatient care and facility fees. [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 reimbursement rates.

Downside risk: Healthcare provider contracts which include financial risk associated with cost and quality of care against established cost or quality benchmarks. In models with downside risk—sometimes called "two-sided risk"— healthcare providers are financially responsible for failure to meet cost and quality benchmarks and risk can be assumed solely by providers or shared between providers and payers.

Fee-for-service (FFS): A negotiated or payer-specified payment rate for every unit of service providers deliver, without regard to quality, outcomes or efficiency. [APM Framework Category 1]

Fee-for-service- (FFS) based 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 3B]

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; and health informational technology infrastructure use. This 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 percentage of premium population-based payments: A fixed dollar payment to providers for all the care that a patient population may receive in a given 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]

Health Care Payment Learning Action Network (HCP-LAN): A collaborative initiative established by the U.S. Department of Health and Human Services to advance the adoption of value-based payment models in the healthcare system. Launched in 2015, the HCP-LAN aims to align healthcare payments with quality and efficiency, promoting better health outcomes and cost savings. It serves as a forum for public and private stakeholders, including providers, payers, patients, and policymakers, to share best practices, develop common frameworks, and accelerate the transition from FFS to APMs that incentivize high-quality, coordinated care. The HCP-LAN has

developed an APM Framework, which categorizes payment models into four major categories based on the degree of financial risk and the potential for care coordination (see **Table 1**).

Integrated finance and delivery system payments: 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. [APM Framework Category 4C]

Insurance carrier (Carrier): A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, and Medicare Advantage plans.

Legacy payments: Payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. These can include fee-for-service, diagnosis-related group (DRG) and per diem payments. [APM Framework Category 1]

Linked to quality: Payments that are set or adjusted based on evidence that providers meet quality standards or have improved care, including for providers who report quality data, or providers who meet a threshold on 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.

Longitudinal relationship: This is defined as a care relationship where the provider has attributed patients from whom they serve as a coordinator of overall care.

At minimum, this longitudinal relationship needs to be six (6) months and often can be determined on a yearly basis in APMs. 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.

Exclusions: A three-month episode for a hip/knee replacement or other such service does not qualify as a longitudinal relationship.

Medicare Advantage market: For the purposes of this report, the Medicare Advantage market 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, such spending is included.

Patient-centered medical home (PCMH): A model of primary care delivery that emphasizes patient-centered, comprehensive, coordinated, accessible, and quality care. The primary goals of the PCMH model are to improve health outcomes, enhance the patient experience, and reduce healthcare cost growth.

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 Category 2C]

Payment period: The 12-month calendar year period applicable to the specified APM report, (e.g., CY2022: January 1 - December 31, 2022, or the most current 12-month period).

Population-based payments that are 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 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: 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 this report, provider means an entity with which an insurance carrier or the Department of Social Services (DSS) contracted for the delivery of covered services, and which received payment for services delivered during the payment period. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, long-term care and durable medical equipment spending to the greatest extent possible and excludes dental and vision policies.

Total cost of care (TCOC): A measure that encompasses all costs associated with delivering healthcare services to a patient population over a specific period. It includes all payments associated with the provision of medical care to the defined population and is used to assess the financial efficiency and effectiveness of healthcare delivery. TTCOC, as defined by the HCP-LAN and as used in this report, 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 the patient's costs; it can be a significant subset of a patient's costs.

TCOC may cover 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 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., CMS' Primary Care First model has a measure of Total Per Capita Cost for aligned beneficiaries), however, capitation arrangements or financial risk for TCOC would also count as accountability for TCOC.

- Example 1: A TCOC arrangement that excludes drug-benefit-related costs can still be considered a TCOC arrangement.
- Example 2: A TCOC arrangement that is for a patient's primary care services, but not the patient's specialty or facility-related costs can still be considered a TCOC arrangement.
- Example 3: An episode-based model of 6-months or longer that excludes unrelated services, outliers, and other select exclusionary criteria (e.g., major traumas) can still be considered a TCOC arrangement.
- Example 4: An arrangement that only covers wellness or preventive care is not considered a TCOC arrangement.

Total dollars: The total estimated in- and out-of-network healthcare spend (e.g., annual payment amount) made to providers in the applicable payment period.

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, if 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.

Upside risk: Healthcare provider contracts with payers where providers share in the savings and not the risk of loss. The uncertainty associated with potential financial risk for the actual cost of care or quality against established cost or quality benchmarks. Models with upside risk—sometimes called "one-sided risk" or "shared savings"—reward providers for meeting cost or quality benchmarks but do not penalize providers for failure to do so.

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's former 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 target.

Value-based care: A spectrum of health care delivery models designed to realign financial incentives and other aspects of the health care system to hold providers accountable for improving patient outcomes.