CONNECTICUT
Health Strategy

Alternative Payment Model Monitoring: 2023

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Acting Commissioner

Pursuant to Conn. Gen. Statute §19a-754a

December 1, 2025

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Acknowledgements

The Connecticut Office of Health Strategy expresses appreciation to the individuals and organizations who provided invaluable contributions to advance this work. We extend sincere thanks to Aetna, Anthem Blue Cross and Blue Shield, Cigna, ConnectiCare, and UnitedHealthcare for submitting data for this report and for their cooperation and collaboration on this initiative. This work was made possible through technical assistance provided by Bailit Health.

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Acronyms

Acronym	Term
ACO	Accountable care organization
AHEAD	Achieving Healthcare Efficiency through Accountable Design
APM	Alternative payment model
CMS	Centers for Medicare and Medicaid Services
COE	Center of Excellence
DRG	Diagnosis-related group payment
DSS	Connecticut Department of Social Services
FFS	Fee-for-Service
HCP-LAN	Health Care Payment Learning and Action Network
MSSP	Medicare Shared Savings Program
OHS	Office of Health Strategy
OIG	Office of the Inspector General
OSC	Office of the State Comptroller
PCG	Primary care group
PCMH	Person-Centered Medical Home
PCP	Primary Care Practitioner
PMPM	Per member per month
TCOC	Total cost of care

Executive Summary

Alternative payment models (APMs) pay providers for providing high-value care and maintaining patient health, often by focusing on primary and preventive care. APM adoption aligns with the Healthcare Benchmark Initiative's goals of lowering healthcare spending, promoting primary care access, and improving patient and population health outcomes. This report finds that Connecticut has a relatively low adoption of advanced APMs, which have the highest level of risk sharing tied to quality and patient outcomes: of the 1,747,456 covered lives reported in the commercial and Medicare Advantage markets for 2023, only 259,440 (about 15%) were in advanced APMs.

This finding is generally consistent with the inaugural APM report featuring 2022 results published by OHS last year. However, this report provides a more accurate baseline for future comparison as the data verification process resulted in substantial changes to payer 2022 data.

Payers verify the data they submitted the previous year at the same time as they submit data for each new reporting year. This process allows payers to reassess attribution of both funds and lives and make corrections.

This report intentionally does not compare or attribute meaning to differences in the 2022 data initially reported and the 2023 data published here for this reason. This report is intended to reflect a more accurate baseline and will serve as a basis for trend analysis over time.

Broadly, APMs pay healthcare providers for better patient outcomes, so that healthier patients with well-managed conditions lead to higher payments. APMs contrast with traditional fee-for-service (FFS) structures that pay healthcare providers for how many services they provide. Evidence suggests that APMS can reduce costs and improve outcomes by prioritizing quality and value over quantity and cost of services.

Connecticut, like most states, relies primarily on FFS structures. FFS is one reason the United States has the highest cost healthcare system among developed nations yet produces health outcomes and life expectancy that lag behind other industrialized countries.[1]

New opportunities such as the U.S. Centers for Medicare and Medicaid Services (CMS) Achieving Healthcare Efficiency through Accountable Design (AHEAD) model (formerly called the Advancing All-Payer Health Equity Approaches and Development model) may provide additional opportunities for the state to implement advanced APMs with a focus on primary care. CMS

[1] 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

selected Connecticut as a Cohort 2 participant in the AHEAD model in 2024. Model implementation is expected to begin in 2028.

APMs can reduce costs and often include a greater focus on primary and preventive care. By reallocating healthcare dollars into higher-quality and higher-value care, APMs can help reduce unnecessary downstream costs such as avoidable hospital use, a significant problem in Connecticut.[2,3]

OHS monitors overall APM adoption in the state, pursuant to Conn. Gen. Statutes § 19a-754a(b)(8)(F). This statutory function supports other Healthcare Benchmark Initiative goals of monitoring policy designed to slow healthcare cost growth and enhance statewide investment in primary care.[4]

OHS uses the Health Care Payment-Learning Action Network (HCP-LAN) framework to classify APMs into four categories, based on the level of payments made through value-based arrangements: Category 1 is a traditional FFS payment model; Category 2 is an FFS model that links to quality (for example, a payment structure that may offer bonuses for quality); Category 3 is FFS with a more significant link to quality (for example, payments that might be based on a combination of quality, cost, and utilization); and Category 4 are models with population-based payments. Categories 3 and 4 are further split into 3A and 3B based on the level of risk sharing, and 4A, 4B, and 4C based on the level of population-based payments. Categories 3B and above (3B, 4A, 4B, and 4C), such as shared savings and risk programs, more strongly emphasize value-based care and deter volume-based care and are called advanced APMs.

This report on APM adoption in Connecticut based on calendar year 2023 data shows that:

- **Commercial and Medicare Advantage adoption remains low -** Approximately 260,000 covered lives in Connecticut, or 15% of the combined commercial and Medicare Advantage markets, were in advanced APMs.

- **Adoption of advanced APMs lags the national average -** Connecticut adopted a smaller proportion of advanced APM models than the nation in the commercial and Medicare Advantage markets.

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[2] Connecticut Office of Health Strategy. (2025). Scorecard Shows Need for Continued Focus on HealthCare Access, Affordability and Equity in Connecticut. https://portal.ct.gov/ohs/press-room/press-releases/2025-press-releases/scorecard-shows-need-in-connecticut?language=en_US

[3] Radley, D. C., Kolb, K., and Collins, S. R.. (2025, June 18). 2025 Scorecard on State Health System Performance: Fragile Progress, Continuing Disparities. Commonwealth Fund. https://www.commonwealthfund.org/publications/scorecard/2025/jun/2025-scorecard-state-health-system-performance

[4] Brown, S.H. et al (2025) State Investments in Primary Care—5 Early Leaders of a Potential Policy Trend. JAMA Health Forum Published Online: 2025;6;(9):e253505. doi:10.1001/jamahealthforum.2025.3505

- **The proportion of fee-for-service spending remains high -** Nearly half of all 2023 spending in the commercial (44%) and Medicare Advantage (48%) markets was fee-for-service (i.e., payments not linked to quality or patient outcomes).

- **Adoption of advanced APMs varies by payer -** Anthem led all payers with 32% advanced APM adoption in the commercial market and 38% in the Medicare Advantage market, while others had virtually no advanced APM adoption in these markets in 2023.

OHS will continue to monitor and report on APM adoption and its effects on healthcare affordability, quality, equity, and primary care investments. OHS will also continue, in collaboration with the Department of Social Services (DSS), to advance opportunities for provider participation in APM models through the CMS AHEAD demonstration program and other initiatives.

Introduction

Connecticut's healthcare system predominantly uses a FFS financial structure that pays providers for each service they provide. Under this traditional FFS payment model, providers are rewarded for providing more billable services, which may incentivize them to increase volume of patients they see and services they provide. Evidence shows that FFS models increase spending by increasing the volume and intensity of healthcare services.[5,6]

Widespread use of FFS payment structures impacts healthcare costs, access, equity, and quality.

- **Costs:** The United States spends more on healthcare than any other comparable, high-income country.[7] In Connecticut, healthcare costs are rising rapidly, compromising Connecticut residents' and employers' ability to afford healthcare.[8]

- **Access and equity:** Healthcare costs pose an access barrier to an alarmingly high proportion of Connecticut residents. A September 2025 survey found that 77% of Connecticut residents with individually purchased coverage and 63% of those with employer sponsored commercial insurance went without care due to costs in the preceding 12 months.[9] The same survey found that lower-income respondents and respondents with disabilities were more likely to go without care due to costs, indicating that healthcare cost in Connecticut is a serious health equity issue.[10]

[5] 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/

[6] Helmchen, LA., LoSasso, AT. (2010). How sensitive is physician performance to alternative compensation schedules? Evidence from a large network of primary care clinics. *Healthcare Economics*.

[7] Wager, E., McGough, M., Rakshit, S., Amin, K., & Cox, C. (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/

[8] Connecticut Office of Health Strategy. (2025). Cost Growth Benchmark Initiative 2022-2023 Performance. https://portal.ct.gov/ohs/-/media/ohs/cost-growth-benchmark/benchmark-reports-py2023/ohs-hcbi-cost-growth-benchmark-report-py2023-rev-4242025.pdf?rev=660aed5028e744cb88c8e04401cc914c

[9] Healthcare Value Hub. (2025, September). Connecticut Consumer Healthcare Experience State Survey. Altarum. https://healthcarevaluehub.org/consumer-healthcare-experience-state-survey/connecticut

[10] Ibid.

- **Quality:** Evidence shows that the nation's high spending on healthcare has not translated into better outcomes: the United States has average or worse health outcomes on a range of quality metrics compared to other high-income countries that spend substantially less on healthcare.[11]

Transitioning away from FFS spending to APMs is a key strategy for addressing high healthcare spending, health inequities and care quality, while improving access to care. APMs compensate providers for providing high-quality and high-value care. By shifting financial incentives, APMs can enable clinicians to focus on comprehensively addressing patients' needs and improving health outcomes.

APM design and execution are crucial for outcomes: *APM effectiveness depends on program design, contract details, and execution. For example, to reduce healthcare costs, APMs need to offer sufficient financial incentives for outcomes and quality-focused interventions or build out innovative population health strategies.*

To encourage further APM adoption in the state, 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 APMs in Connecticut. OHS does this by 1) tracking the total spending through APMs and 2) the number of covered lives attributed to providers participating in various types of APMs. This is the second year that OHS has tracked and reported APM adoption (the inaugural report was published in October 2024).

Connecticut is one of at least ten other states collecting data on APM adoption (Arizona, California, Colorado, Delaware, Maine, Maryland, Massachusetts, Oregon, Rhode Island, and Washington), reflecting nationwide interest in this strategy.[12] For Connecticut, expanded APM adoption has the potential to help the state achieve improved performance on OHS-established healthcare benchmarks for care quality, primary care investment, and healthcare spending growth. By tracking and reporting this data, OHS intends to enhance stakeholder understanding of statewide adoption of APMs and identify areas for improvement and expansion.

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[11] Wager, E. and Cox, C. (2024, May 28). International Comparison of Health Systems. KFF. https://www.kff.org/health-policy-101-international-comparison-of-health-systems/?entry=table-of-contents-how-does-quality-of-care-in-the-u-s-compare-to-other-countries

[12] Maryland Health Care Commission. (2024). Maryland Commercial Fully-Insured Market Alternative Payment Model Arrangements. https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/2024/apm_rpt_2024.pdf

Existing Research

Evidence on the impact of APMs on cost, quality, and patient outcomes is mixed but promising.[13] For example, the Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts' ACO program, improved quality compared to other New England and national populations and led to an 11.7% relative savings on claims.[14] A 2018 study of the Medicare Shared Savings Program (MSSP) showed savings for participating physician-led ACOs, while savings in hospital-integrated ACOs were offset by quality bonus payments.[15] A 2017 report from the Office of the Inspector General (OIG) found that MSSP ACOs generated $1 billion in savings during the first three years of the program. OIG found that MSSP ACOs outperformed fee-for-service providers on the majority (81%) of quality measures.[16]

In a systemic review of commercial market APM studies, almost 70% had a positive outcome: 81% of studies showed a positive quality outcome while 56% and 58% of studies showed positive impacts on spending or utilization, respectively.[17]

APMs vary greatly in design, with some implementing pay for performance and others implementing bundled payments (for a set of services) or shared risk.[18,19] These plan differences can either hinder or enhance their success. OHS encourages implementing APMs according to best practices and existing research to achieve cost growth containment and better patient outcomes.

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[13] Dreyer, T. & Maddox, K. J. (2023, March 30). What's the Value in Value-Based Care? AAMC. https://www.aamc.org/about-us/mission-areas/health-care/whats-value-value-based-care

[14] 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.

[15] 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.

[16] 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/documents/evaluation/2670/OEI-02-15-00450-Complete%20Report.pdf

[17] Milad, M., Murray, R., Navathe, A., & Ryan, A. (2022, April). Value-Based Payment Models In The Commercial Insurance Sector: A Systematic Review. *Health Affairs*. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01020

[18] Howard, S.W., Bradford, N., Belue, R., Henning, M., Qian, Z., Ahaus, K., & Reindersma, T. (2024, June). Building alternative payment models in health care. *Front Health Serv*. https://pmc.ncbi.nlm.nih.gov/articles/PMC11211624/#abstract1

[19] Cattel, D. & Eijkenaar, F. (2020, December). Value-Based Provider Payment Initiatives Combining Global Payments With Explicit Quality Incentives: A Systematic Review. *Med Care Res Rev*. https://pmc.ncbi.nlm.nih.gov/articles/PMC7536531/#abstract1

Implementing APMs will not be without obstacles. For example, APMs are often implemented as pilot programs, which impacts efficiencies of scale, and they typically work best when combined with other complementary initiatives.[20]

Connecticut State APM Advancement

Connecticut agencies are working to implement two new APMs: CMS' AHEAD Model and DSS' maternity bundle program. Additionally, the Office of the State Comptroller (OSC), which manages the state employee health benefit plan, has implemented a primary care focused shared savings and quality bonus initiative.

AHEAD

AHEAD is a multi-payer voluntary total cost of care model that offers Connecticut hospitals and primary care practices new opportunities to participate in innovative payment models. Hospitals can participate in a global budget payment model that sets a prospective fixed revenue amount for the upcoming year for all payers including Medicare, Medicaid and commercial insurance. This payment structure may provide hospitals with more stable, predictable funding, enabling them to invest in strategies to enhance care coordination and reduce or eliminate avoidable hospitalizations. A global budget provides a financial incentive to provide more efficient, value-based care.

Connecticut primary care practices participating in the model will receive a Medicare management fee designed to help advance person-centered care. The Department of Social Services (DSS) has the opportunity to align these practices with ongoing Medicaid primary care transformation efforts. Federally qualified health centers will also be eligible to participate. This payment structure has the potential to improve the quality and accessibility of primary care services.

In 2024, Connecticut was one of six states selected to participate in the AHEAD model. Connecticut is part of Cohort 2 of the AHEAD model, which operates from 2024-2035. The state is in the pre-implementation phase and is expected to launch the model in 2028. The state will receive approximately $12M in federal funding to support implementation. Public Act 25-168 § 47 requires DSS, within available appropriations, to develop alternative payment methodologies including global budget methodologies.

AHEAD complements Connecticut's efforts to give providers greater flexibility and support beyond what FFS models provide, allowing them to focus on prevention and strengthening primary care. Additionally, the AHEAD model - which requires statewide accountability measures on cost,

[20] Bazemore, A., Phillips, R.L., Glazier, R., & Tepper, J. (2018, May). Advancing Primary Care Through Alternative Payment Models: Lessons from the United States & Canada. *Journal of the American Board of Family Medicine*. https://www.jabfm.org/content/31/3/322#sec-4

quality, and primary care investment - aligns and supports OHS' existing cost growth benchmark, quality benchmark, and primary care spending target programs.

Medicaid Maternity Bundle

DSS has transitioned from a fee-for-service payment model for maternity care to a Maternity Payment Bundle, which uses an episode-based payment and case rate methodology for most Connecticut Medicaid enrolled maternal health providers. This transition is designed to advance health equity, reduce maternal and infant morbidity and mortality, and address longstanding disparities in care. The payment bundle covers the full spectrum of maternity services, including new benefits like doula care and breastfeeding support, while incorporating quality and outcome measures to promote higher-value, patient-centered care.

Office of the State Comptroller Primary Care Initiative

The Office of the State Comptroller operates the state employee, retiree and partnership health benefit plan, covering more than 241,000 lives. The OSC Primary Care Initiative (PCI) gives participating advanced primary care organizations enhanced care coordination fees (category 2A), quality bonus (2C) and shared savings (3B) opportunities to invest in activities aimed at improving population health and reducing overall healthcare costs. The alternative payments paid out more than $2.4 million in quality bonuses in 2023 while projected savings to the state total more than $3 million. More information is available in OHS' Primary Care Spending Report and from OSC's Healthcare Update. See Table 1 for HCP-LAN Categories.

Methodology

This section summarizes OHS's APM data collection and analysis methodology. Please see the implementation manual posted on OHS's webpage for the detailed APM data specifications.[21]

Data Sources

OHS collected 2022 and 2023 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 requested but did not receive any data from Wellcare. In this report, OHS reports on spending for 2022 and 2023 (focusing on 2023) and covered lives for 2023, where data is available.

Of the 1,747,456 covered lives reported in the commercial and Medicare Advantage markets for 2023, only 259,440 (about 15%) were in advanced APMs. In the commercial market, 166,549 (12%) of 1,334,643 commercial covered lives were in an advanced APM. In the Medicare Advantage market, 92,891 (23%) of 412,813 Medicare Advantage covered lives were in an advanced APM model. Note that due to resubmissions from payers for 2022 calendar year data, the 2022 calendar year data in this report may differ from the 2022 calendar year data in the 2023 report.

APM Categories

OHS uses the Health Care Payment-Learning Action Network (HCP-LAN) framework, which many insurers are already familiar with, to assign spending into different categories of APMs. HCP-LAN is a nonprofit alliance of public and private healthcare experts, who developed a framework to ensure a shared way to classify and design APMs and measure their progress. HCP-LAN classifies payment models into four different categories based on the extent to which payments reward value rather than volume of services, as outlined in Table 1 below.[22] Using this framework allows OHS to more easily compare Connecticut's APM adoption to national data and over time.

[21] Connecticut Office of Health Strategy. (2024). Alternative payment model measurement implementation manual. https://portal.ct.gov/ohs/-/media/ohs/cost-growth-benchmark/public-hearing/ct-ohs-apm-implementation-manual-v20-2024-6-18.pdf?rev=add69688bd684fbe8a9ffdc8991c399f&hash=08785E34CD3F05C73758C74AAF338B85

[22] Health Care Payment Learning and Action Network. (2017). Alternative payment model framework. https://hcp-lan.org/apm-framework/

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.
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, adjusted based on whether providers report quality data, or adjusted based on how well providers perform on certain cost and quality metrics. Examples include: • **Category 2A**: Foundational Payments for Infrastructure and Operations: Payments to improve care delivery such as care coordination fees and for health information technology investments. • **Category 2B:** Pay-for-Reporting: Bonus payments/rewards for reporting on specified quality measures. • **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); person-centered medical home (PCMH) with retrospective shared savings (no shared risk); specialty Center

Category #	Category Description
	of Excellence (COE) with retrospective shared savings (no shared risk). • **Category 3B:** APMs with upside gain sharing and downside (shared) 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 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 and 2023 APM data. First, the data reflect the payments made to Connecticut providers during the calendar year (e.g., January 1, 2023 – December 31, 2023) or, for contracts that do not follow the calendar year, the most recent 12-month period (e.g., October 1, 2022 – September 30, 2023).

Second, when providers participated in multiple APMs, insurers were instructed to allocate payment amounts 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, then all FFS claims, shared savings payments and the performance bonuses in this contractual arrangement are included in the shared savings category (Category 3).

Third, OHS is working with DSS to collect and analyze the most accurate Medicaid payment data. While this data is not included for the 2023 payment period, OHS intends to include the Medicaid data in future reporting.

APM Adoption in the Commercial Market

This section presents 2022 and 2023 data, with a focus on 2023, that illustrate commercial market APM adoption in Connecticut and nationally.

State and National Commercial Adoption, 2023

In the Connecticut commercial market in 2023, nearly half (44%) of commercial spending was attributed to Category 1 models, which are traditional FFS models with no link to quality; 12% of spending was in Category 2 (i.e., FFS spending that included a link to quality, like pay-for-performance or pay-for-reporting incentives); 43% through Category 3 APMs (i.e., APMs built on a FFS architecture, including shared savings and episode-based arrangements); and less than 1% of spending was in Category 4 (i.e., population-based payment) (see Figure 1 and Table 2).

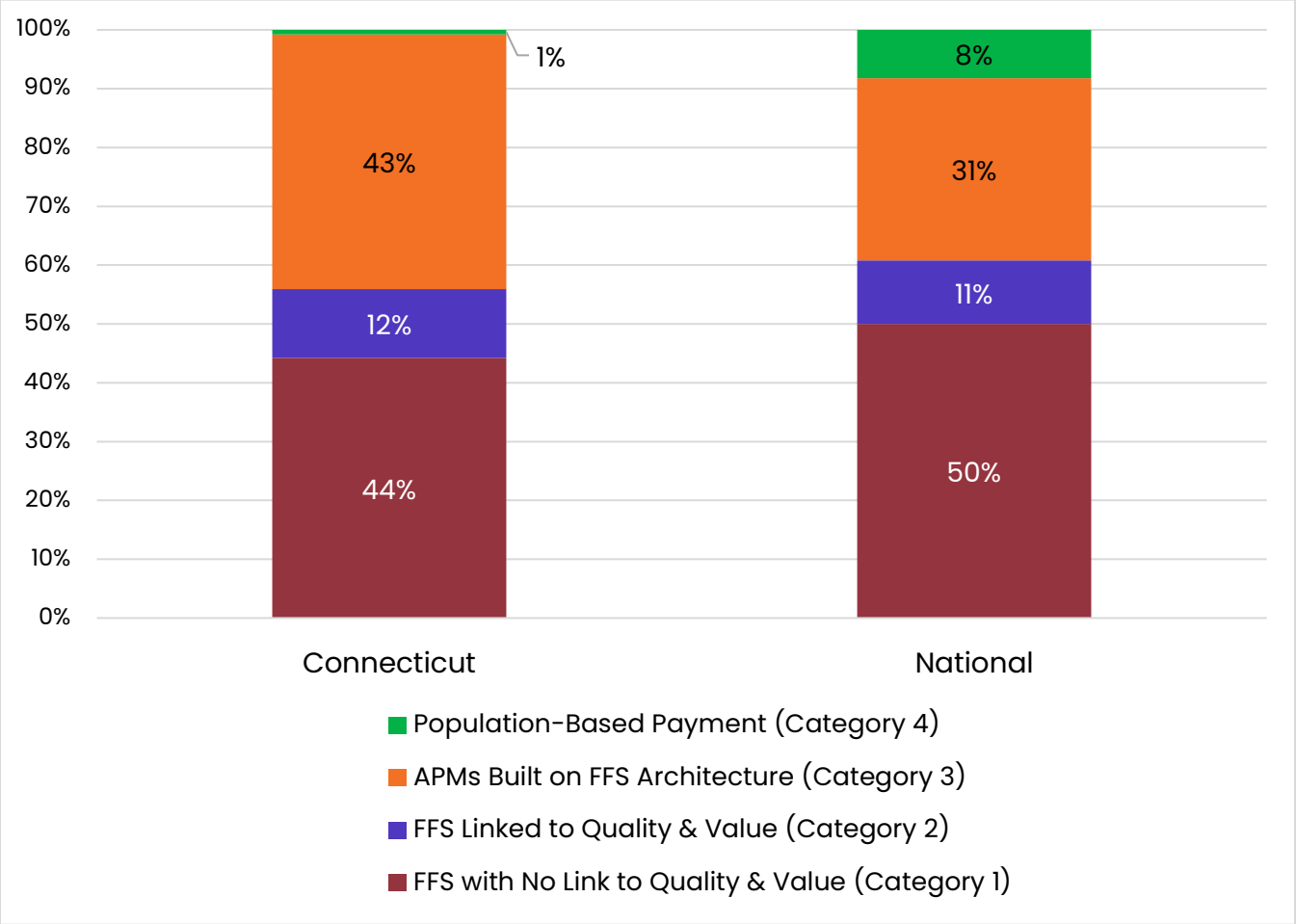
OHS compared Connecticut's 2023 APM spending to the HCP-LAN's national survey results (see Figure 1), which represents about 72% of the commercial market nationally.[23] Overall, Connecticut saw slightly less spending made through Category 1 fee-for-service models that do not link to quality (44% compared to 50%, nationally). This indicates that a larger proportion of Connecticut's APM spending was linked to quality. Still, with almost half of all commercial spending in Category-1 FFS models with no quality link, there is ample room for improvement.

Connecticut saw less than 1% adoption in Category 4 APM models, which evidence suggests may be the most impactful APM on quality and cost-savings, compared to a national adoption rate of 8%. See section A Closer Look at Advanced APMs (Categories 3B-4C) in the Commercial Market, Statewide and by Payer, 2023 below for further analysis of advanced APMs.

[23] Health Care Payment Learning and Action Network. (2024). 2024 APM Measurement. https://hcp-lan.org/apm-measurement-effort/2024-apm/

APM Adoption in the Commercial Market

Figure 1. Percentage of Commercial Spending by APM Category, 2023



Note that values may not add up to 100% due to rounding.

APM Adoption in the Commercial Market

Table 2. Connecticut Commercial APM Spending and Lives by Category and Subcategory, Calendar Year 2023

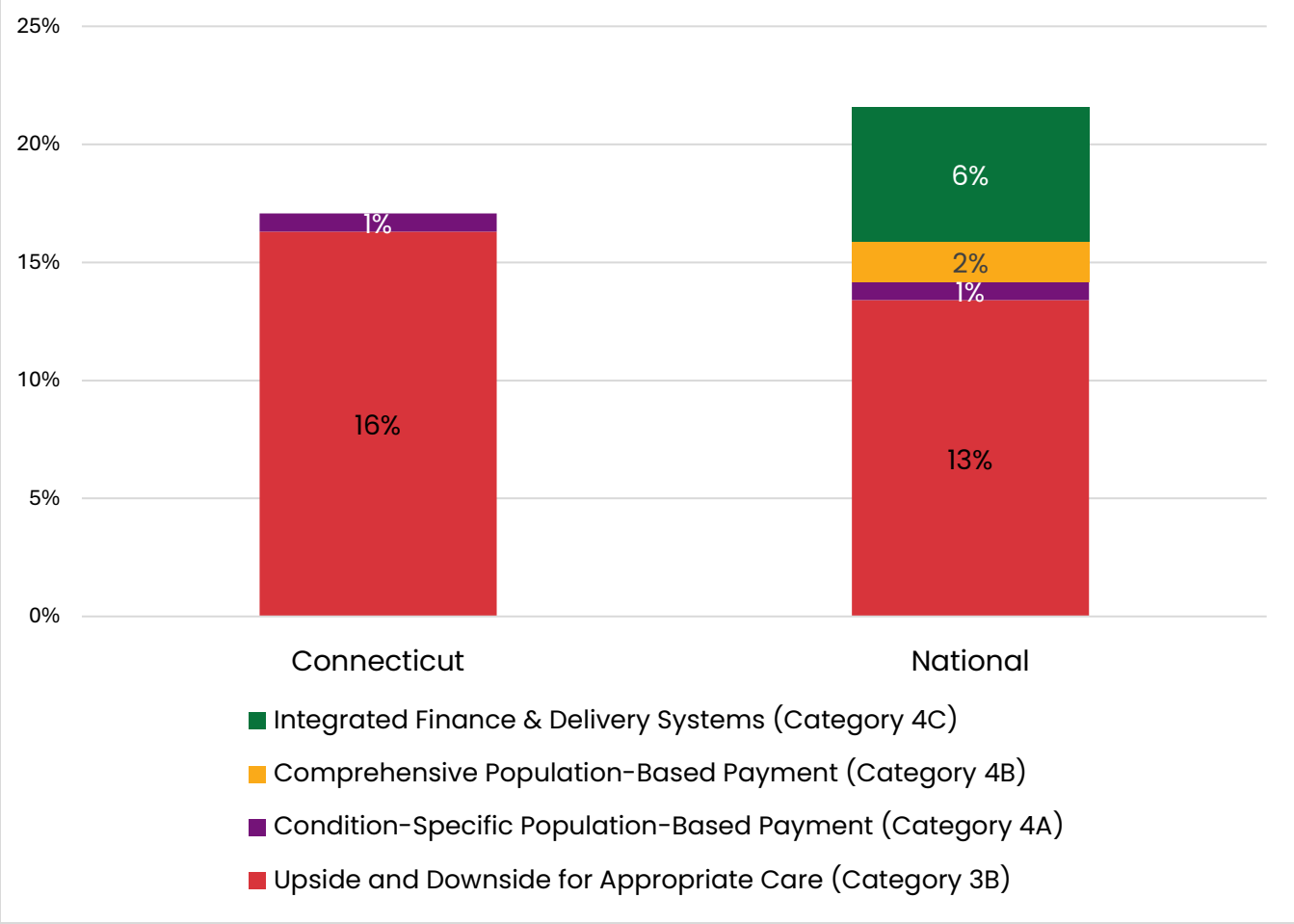
Category	Category Description	2023 Covered Lives	2023 Spending	2023 Percent of Total Spending
CATEGORY 1	**Fee For Service**	**Not Available**	**$4,012,496,580**	**44%**
CATEGORY 2	**Fee for Service Linked to Quality & Value**	**Not Available**	**$1,063,460,763**	**12%**
2A	Foundational spending to improve care		$1,526,746	0.02%
2B	FFS plus pay-for-reporting		$527,262,241	6%
2C	FFS plus pay-for-performance		$534,671,775	6%
CATEGORY 3	**APMs Built on FFS Architecture; PCP Focused**	***462,796****	**$3,928,072,309**	**43% Spending; 35% Lives**
3A	Traditional shared savings		$2,387,616,038	26%
3A	Utilization-based shared savings		$61,521,011	1%
3B	FFS-based shared risk		$1,328,001,430	15%
3B	Procedure-based bundled/episode payments		$150,933,830	2%
CATEGORY 4	**Population-based Payment; PCP Focused**	***7,017****	**$70,746,712**	**0.8% Spending; 0.5% Lives**
4A	Condition-specific population-based payments		$42,064,009	0.5%
4A	Condition-specific bundled/episode payments		$28,681,293	0.3%
4B	Population-based payments that are NOT condition-specific		$0	0%
4B	Full or percent of premium population-based payment		$0	0%
4C	Integrated finance and delivery system programs linked to quality		$1,411	0%
	TOTAL CATEGORIES 2, 3 & 4:	**Not Available**	**$5,062,279,784**	**56%**
	TOTAL ALL CATEGORIES:	**1,334,643**	**$9,074,776,364**	**100%**

Note The above table displays only the covered lives attributed to a primary care provider (PCP) or primary care group (PCG) because OHS's data on covered lives attributed to specialist providers cannot be disaggregated beyond Categories 3 and 4.

A Closer Look at Advanced APMs (Categories 3B-4C) in the Commercial Market, Statewide and by Payer, 2023

Advanced APMs (Categories 3B, 4A, 4B, and 4C) can promote patient-centered care with downside risk and population-based payments. While Connecticut had comparable proportions of spending made through Categories 3B and 4A to the nation in 2023, Connecticut lacked any spending made through Category 4B and 4C arrangements, which are the most advanced APM models (see Figure 2). (One carrier, Aetna, originally reported approximately $110 million in spending in Category 4B in 2022. However, in their resubmission of this data, they updated their 2022 data to report zero dollars through Category 4B, leading CT to have zero reported dollars through Category 4B, which continued into 2023.)

Figure 2. Percentage of Commercial Spending by Advanced APM Category (Categories 3B-4C), 2023



Note that these percentages are of the total APM (all category) dollars. The percentage of commercial spending in Categories 4B or 4C in Connecticut was 0.0% for the reporting period.

Payers varied in their adoption of advanced APMs in 2023 (see Table 3). The payers that reported the most spending through advanced APMs in 2023 were Anthem (32%), Cigna (13%), and UnitedHealthcare (11%). Aetna and ConnectiCare reported 0% (although ConnectiCare's comparatively low enrollment may make APMs impractical). Only two payers reported any spending through Category 4A: Cigna and UnitedHealthcare (2% of spending each).

Table 3. Percentage of Commercial Spending by Advanced APM Category by Payer, 2023

Category	Aetna	Anthem	Cigna	ConnectiCare	UnitedHealthcare
3B: FFS-based shared risk	0%	32%	0%	0%	8%
3B: Procedure-based bundled/episode payments	0%	0%	11%	0%	1%
4A: Condition-specific population-based payments	0%	0%	0%	0%	2%
4A: Condition-specific bundled/episode payments	0%	0%	2%	0%	0%
4B: Population-based payments that are NOT condition-specific	0%	0%	0%	0%	0%
4B: Full or percent of premium population-based payment	0%	0%	0%	0%	0%
4C: Integrated finance and delivery system programs linked to quality	0%	0%	0%	0%	0%
CATEGORIES 3B-4C	**0%**	**32%**	**13%**	**0%**	**11%**

Note that these percentages are of the total APM (all category) dollars.

APM Adoption in the Medicare Advantage Market

This section presents 2022 and 2023 data, with a focus on 2023, on Medicare Advantage market APM adoption in Connecticut and nationally.

State and National Medicare Advantage Adoption, 2023

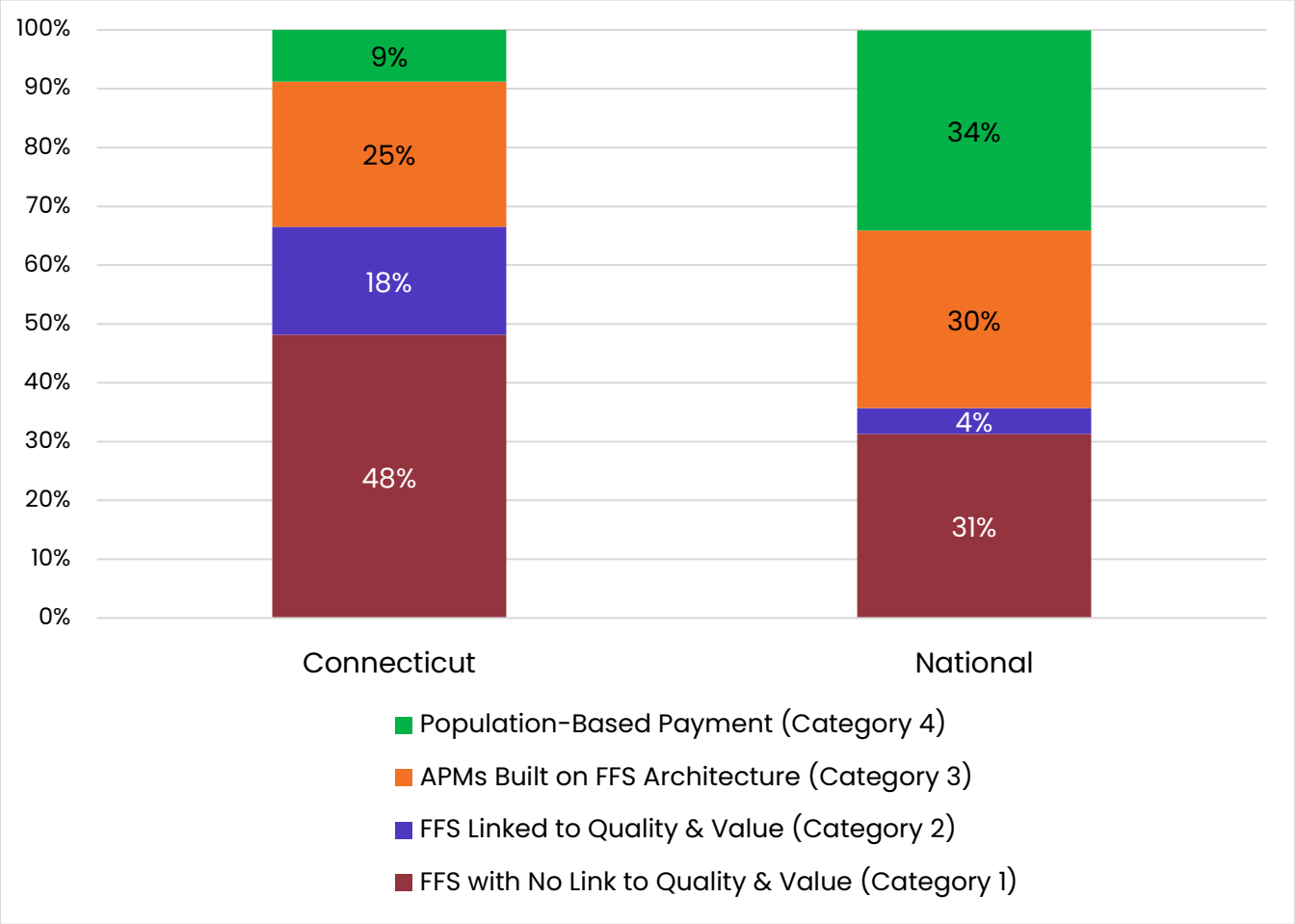
The Medicare Advantage market has 18% of spending in Category 2, 25% in Category 3, and 9% in Category 4 (see Figure 3 and Table 4).

Nationally, a smaller proportion of spending is made through traditional, fee-for-service Category 1 spending (31%) than in Connecticut (48%) in the Medicare Advantage market. Connecticut has a higher percentage of Category 2 spending than the national average (see Figure 3). In addition, most spending nationally is made through Category 3 and 4 arrangements (64%), while spending made through Category 3 and 4 arrangements accounts for a much smaller proportion of spending in Connecticut (34%).

In comparing state to national trends, note that HCP-LAN's Medicare Advantage data represent about 70% of the national Medicare Advantage market.

APM Adoption in the Medicare Advantage Market

Figure 3. Percentage of Medicare Advantage Spending by APM Category, 2023



Note that values may not add up to 100% due to rounding.

APM Adoption in the Medicare Advantage Market

Table 4. Connecticut Medicare Advantage APM Spending and Lives by Category and Subcategory, Calendar Year 2023

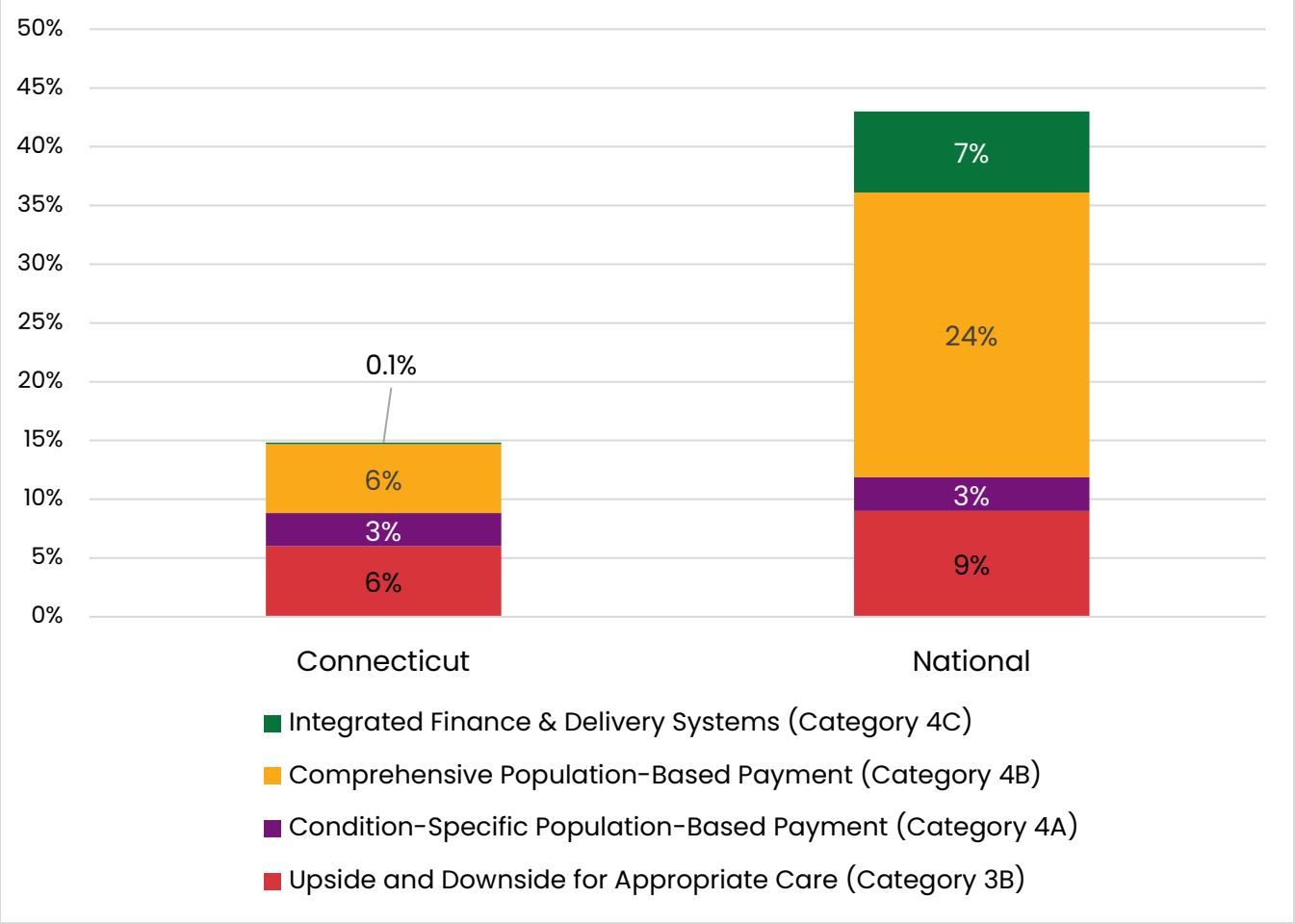
Category	Category Description	2023 Covered Lives	2023 Spending	2023 Percent of Total Spending
CATEGORY 1	**Fee For Service**	**Not Available**	**$2,962,480,343**	**48%**
CATEGORY 2	**Fee for Service Linked to Quality & Value**	**Not Available**	**$1,127,263,334**	**18%**
2A	Foundational spending to improve care		$0	0%
2B	FFS plus pay-for-reporting		$0	0%
2C	FFS plus pay-for-performance		$1,127,263,334	18%
CATEGORY 3	**APMs Built on FFS Architecture; PCP Focused**	***107,324****	**$1,516,759,679**	**25% Spending; 26% Lives**
3A	Traditional shared savings		$1,146,820,933	19%
3A	Utilization-based shared savings		$0	0%
3B	FFS-based shared risk		$369,938,745	6%
3B	Procedure-based bundled/episode payments		$0	0%
CATEGORY 4	**Population-based Payment; PCP Focused**	***43,865****	**$541,595,803**	**9% Spending; 11% Lives**
4A	Condition-specific population-based payments		$170,914,973	3%
4A	Condition-specific bundled/episode payments		$849,820	0%
4B	Population-based payments that are NOT condition-specific		$0	0%
4B	Full or percent of premium population-based payment		$361,669,971	6%
4C	Integrated finance and delivery system programs linked to quality		$8,161,039	0.1%
	TOTAL CATEGORIES 2, 3 & 4:	**Not Available**	**$3,185,618,815**	**52%**
	TOTAL ALL CATEGORIES:	**412,813**	**$6,148,099,158**	**100%**

Note that the above table displays only the covered lives attributed to a PCP or PCG because OHS's data on covered lives attributed to specialist providers cannot be disaggregated beyond Categories 3 and 4.

A Closer Look at Advanced APMs (Categories 3B-4C) in the Connecticut Medicare Advantage Market, Statewide and by Payer, 2023

While Connecticut trails the nation in advanced APM adoption in both the commercial and the Medicare Advantage markets, the lag is more dramatic in the Medicare Advantage market, particularly for Categories 4B and 4C (see Figure 4).

Figure 4. Percentage of Medicare Advantage Spending by Advanced APM Category (Categories 3B-4C), 2023



Note that these percentages are of the total APM (all categories) dollars.

Table 5 below shows payer-level variation in adoption of advanced APMs in the Medicare Advantage market. Anthem had the greatest proportion of spending made through advanced APMs in 2023 (38%), with UnitedHealthcare (17%), and Aetna (2%) following. ConnectiCare reported zero spending made through advanced APMs; its comparatively low enrollment may constrain use of such models.

Table 5. Percentage of Medicare Advantage Spending by Advanced APM Category by Payer, 2023

Category	Aetna	Anthem	ConnectiCare	UnitedHealthcare
3B: FFS-based shared risk	2%	29%	0%	2%
3B: Procedure-based bundled/episode payments	0%	0%	0%	0%
4A: Condition-specific population-based payments	0%	8%	0%	3%
4A: Condition-specific bundled/episode payments	0.1%	0%	0%	0%
4B: Population-based payments that are NOT condition-specific	0%	0%	0%	0%
4B: Full or percent of premium population-based payment	0%	0%	0%	12%
4C: Integrated finance and delivery system programs linked to quality	0%	1%	0%	0%
CATEGORIES 3B-4C	**2%**	**38%**	**0%**	**17%**

Note that these percentages are of the total APM (all category) dollars.

Conclusion

APMs are a promising strategy to reorient the focus of the healthcare system to enhance patient satisfaction, improve population health, promote primary care, and reduce overall healthcare expenditures

In the commercial market, Connecticut saw a slightly greater proportion of spending made through Category 2, 3, and 4 APMs (56%) than the nation (50%) in 2023. However, in the Medicare Advantage market, Connecticut's proportion of spending through these APMs (52%) was lower compared to the nation (69%). Connecticut has been slower than the nation to adopt advanced APMs (Categories 4B and 4C), particularly in the Medicare Advantage market. These advanced models may have the strongest potential to achieve cost savings and quality improvement.

Anthem and UnitedHealthcare reported the highest adoption of advanced APMs in both markets with Anthem far ahead of other carriers in adopting APMs in Connecticut. Aetna and ConnectiCare lagged in both markets.

Next Steps

The opportunity exists for Connecticut agencies and carriers to further advance APM adoption, particularly of the advanced Category 4B and 4C arrangements. Widespread adoption of advanced APM models in Connecticut could lead to increased healthcare quality and primary care investment by financially incentivizing the delivery of high-value, coordinated care. Further adoption could also improve healthcare affordability and equity by reducing unnecessary spending and optimizing resource utilization.

OHS will continue to monitor APM adoption in the state and will periodically report on adoption as sufficient data becomes available to assess market changes and trends.

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 and 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 practitioner (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), person-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 time, 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 and 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.

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.

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.

Person-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 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 provision of medical care to the defined population and is used to assess the financial efficiency and effectiveness of healthcare delivery. TCOC, 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, as long as they meet quality targets. Traditional shared savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets.

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.