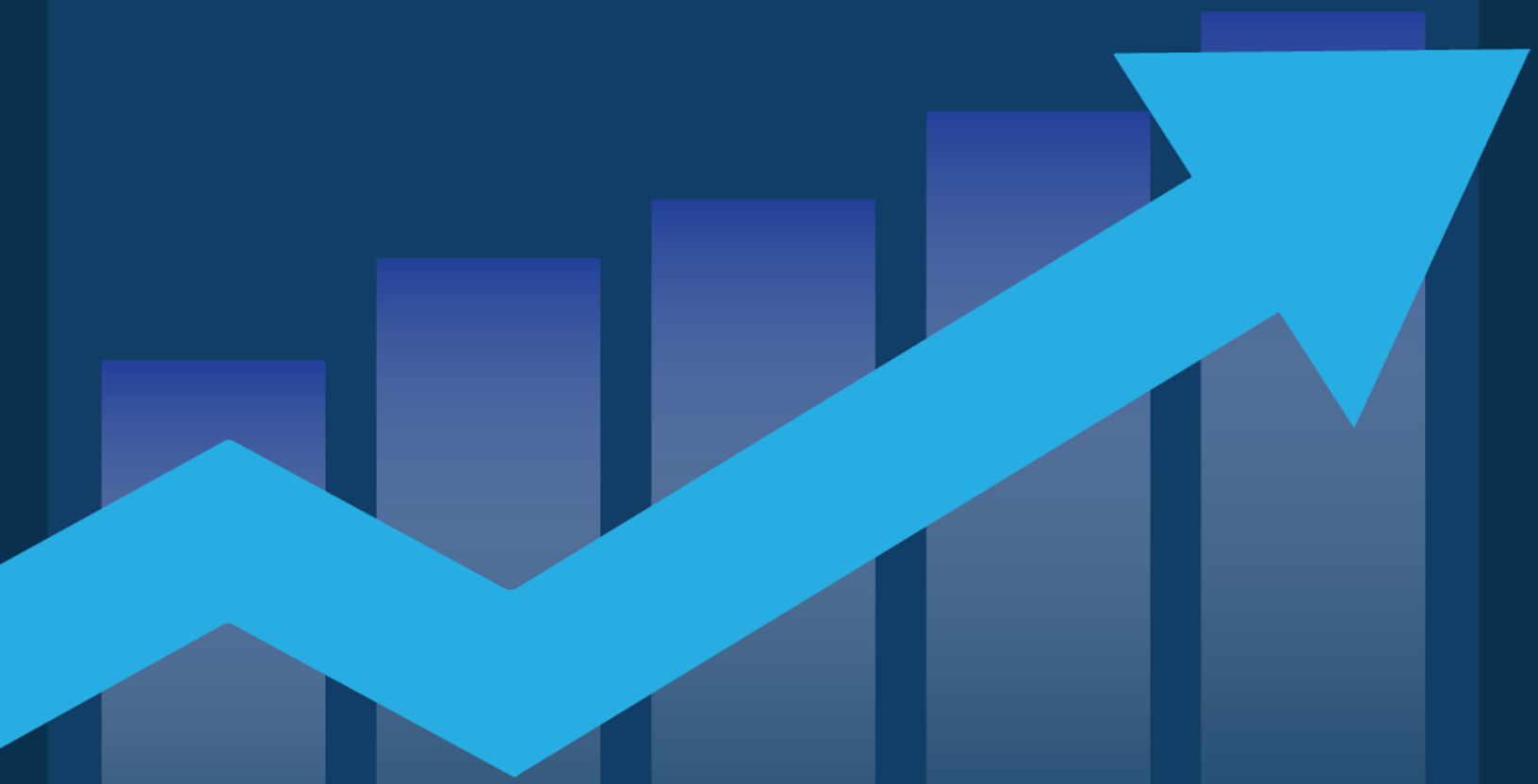
APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS



2025 Methodology and Results Report

AHIP™

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Executive Summary

The Health Care Payment Learning & Action Network (HCPLAN) initially led the national Alternative Payment Model (APM) Measurement Effort ("Measurement Effort" or "survey"), starting in 2016, to evaluate adoption of APMs across lines of business, assess general market trends and track the pace of progress toward APM adoption across commercial health plans, state Medicaid agencies, Medicaid managed care organizations, Medicare Advantage plans, and Original Medicare. Under the HCPLAN's leadership, the Centers for Medicare & Medicaid Services (CMS), AHIP, and the Blue Cross Blue Shield Association (BCBSA) served as survey partners. Beginning in 2025, AHIP assumed leadership of this work, continuing the partnership with CMS and BCBSA. This transition maintained the same measurement framework, data integrity, and partner collaboration established under the HCPLAN, reflecting a seamless shift from federal to industry stewardship and a shared commitment to tracking progress toward value-based care.

The 2025 national APM survey launched in July 2025 and concluded at the end of October 2025. Health plans, states, and Original Medicare provided retrospective data on actual dollars paid to providers in calendar year (CY) 2024 or the most recent 12-month period for which data was available. A total of 58 health plans, two (2) fee-for-service (FFS) Medicaid states, and Original Medicare participated in the 2025 survey, representing over 271 million or 87.5% of individuals covered by an insurance plan in the commercial, Medicare Advantage, Medicaid, or Original Medicare lines of business (LOB).[1]

The 2025 results highlight payments made during CY 2024 for all lines of business. The payments were categorized based on the HCPLAN APM Framework (Figure 1).

In CY 2024, 44.9% of U.S. health care payments flowed through APMs (Categories 3 – 4) across all LOBs, compared to 45.2% in CY 2023; 28.7% flowed through APMs with downside risk (Categories 3B-4) across all LOBs, compared to 28.5% in CY 2023.

The annual measurement effort also continues to track the expected growth in such models as well as barriers and facilitators to APM adoption through informational questions fielded in the survey. Over the next 24 months, 70% of respondents expect APM activity to increase, citing provider readiness, health plan engagement, and health plans' ability to operationalize such models as key facilitators. In addition, 55% of respondents believe the category that will grow the most in the future is 3B—shared risk/procedure-based episode payments.

Overview of the Industry Measurement Effort

The national APM survey measures nationwide progress toward APM adoption to help build a more effective health care system. Nine years ago, the HCPLAN released the first national Measurement

[1] The percentage of the national market is based on a denominator of approximately 310 M lives covered by any health insurance plan. U.S. Census Bureau, "Health Insurance Coverage in the United States: 2025, Current Population Reports." Issued September 2025. Available at Health Insurance Coverage in the United States: 2024 (census.gov). Accessed October 4, 2025. The sources for the individual lines of business vary, and do not total the aggregate denominator. See "Limitations" section.

Effort results assessing the adoption of APMs in the commercial, Medicare Advantage, Medicaid, and Original Medicare lines of business, and subsequently tracked trends over time. Measurement Methodology Results from prior years may be available to view on the Measurement Effort Results page on the HCPLAN website.[2]

Historically, the HCPLAN invited health plans and other payers (e.g., state Medicaid agencies) to participate annually by reporting aggregated payment data to a survey; the HCPLAN would then release results near the end of each calendar year. Participating organizations nationwide use common definitions of key terminology, including categorizing payments using the HCPLAN's APM Framework.

With a change in federal funding, the HCPLAN concluded its leadership of the national APM Measurement Effort in early 2025. Recognizing the importance of continuing to evaluate adoption of payment arrangements tied to quality and maintaining trend lines, AHIP collaborated with BCBSA and CMS to ensure continuous APM data collection. This continued partnership and commitment to measuring APM adoption showcases the industry's ongoing dedication to advancing value-based care and understanding trends in adoption.

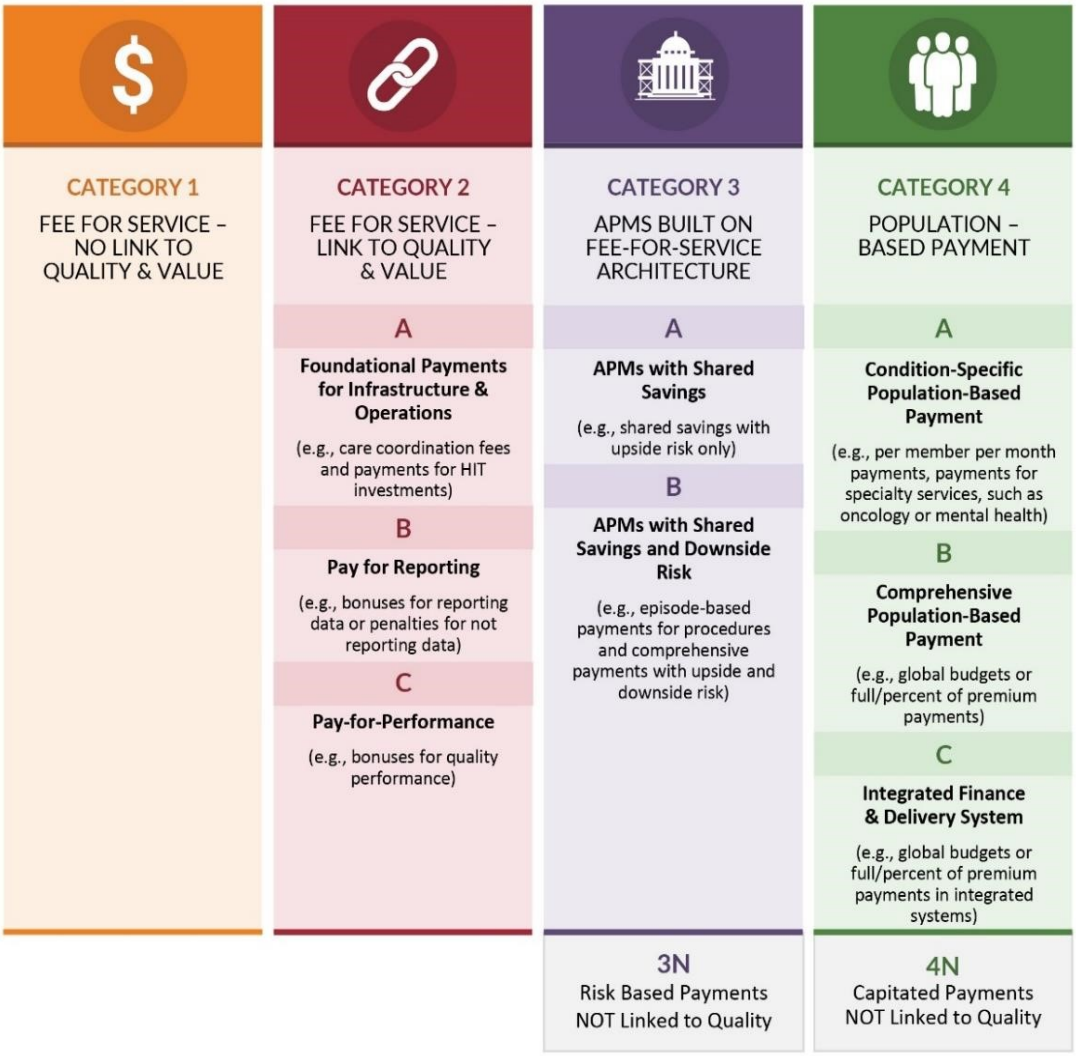
AHIP generally followed the same survey, guidance, methodology, and reporting format that has been used in past efforts. However, given the compressed timeline the survey was shortened to remove two qualitative questions and the metrics that measured the proportion of lives covered in APMs. All remaining questions were kept without changes.

Alternative Payment Models (APMs) Overview

APMs aim to improve health care quality and lower costs by realigning payment incentives to encourage changes in care delivery expected to result in better quality, more affordable care. The HCPLAN was established to accelerate APM adoption and drive alignment in payment reform approaches across the public and private sectors. Participating plans and states categorized payments according to the HCPLAN APM Framework (Figure 1) definitions and methodology.

[2] For HCPLAN Measurement Reports not available on the HCPLAN Measurement Effort website, please reach out to hcplan@rippleeffect.com.

Figure 1: HCPLAN APM Framework



2025 APM Measurement Effort Methodology

The 2025 industry-led APM Measurement Effort, conducted from July to October 2025, collected retrospective data from health plans, states, and Original Medicare on payments made to providers during CY 2024 or the most recent 12-month period for which the data was available. Data was sourced through surveys fielded by AHIP and BCBSA, with CMS providing Original Medicare data directly. The collected data was categorized according to the HCPLAN APM Framework (Figure 1), and results were analyzed for consistency and accuracy by AHIP, BCBSA, CMS and Catalyst for Payment Reform (CPR), ensuring confidentiality and integrity. The methodology also included tracking qualitative questions, such as barriers and facilitators to APM adoption. The aggregated data provides insights into the adoption of APMs across different lines of business.

Data Sources

AHIP fielded a survey to its member health plans, non-member health plans, and states, with the help of CPR who coordinated with states and non-member health plans. BCBSA conducted a survey of its member plans and coordinated with AHIP to identify health plans that are members of both associations to ensure there were no duplicate responses in the data set. CMS contributed Original Medicare data using its internal data sources rather than fielding a survey.

The data collected through the AHIP and BCBSA, as well as the data reported by CMS, is described in Table 1 and Appendix A.

The AHIP Survey

The 2025 survey was fielded by AHIP and administered through Qualtrics software (Qualtrics, Provo, UT). A data dictionary was provided in communications to health plans to promote alignment and consistency across reporting entities. Survey questions captured dollar amounts associated with payment arrangements across all categories of the refreshed HCPLAN APM Framework (Figure 1). AHIP recruited its member health plans through email and phone outreach. Using a key informant approach, AHIP contacted prior-year respondents, government relations, medical, provider contracting, or payment innovation leads, who then coordinated internal completion of the survey. Participants submitted data directly to AHIP through the Qualtrics platform; a small number of respondents provided responses through structured data templates. After submission, AHIP reviewed responses and conducted follow-up outreach to clarify or validate data as needed. For the 2025 effort, AHIP contracted with CPR to assist with recruitment of states, such as state Medicaid agencies, and select health plans who are not members of AHIP or BCBSA. These entities agreed to submit their data to AHIP to be aggregated with all AHIP member plan data and eventually aggregated with all industry data.

The Blue Cross Blue Shield Association (BCBSA) Survey

To collect the required data points, BCBSA included questions in an annual survey of member plans addressing the delivery of value-based health care. BCBSA collaborated with AHIP to ensure alignment of survey questions to facilitate data aggregation.

BCBSA reported the total number of participating plans, and the data elements described in Table 1 and Appendix A, in aggregate for the purposes of measuring multiple payers' adoption of APMs nationally.

Data was collected for health care spending paid to all providers for dates of service in CY 2024 (January 1 to December 31) or the most recent 12-month period. The data elements listed above reflect 2024 data and were submitted to, validated by, and aggregated by BCBSA.

Original Medicare

CMS reported Original Medicare spending in CY 2024 to AHIP. CMS collaborated with AHIP and BCBSA to align methodologies and facilitate data aggregation for reporting national progress. The CY 2024 Medicare Parts A and B data included the total dollars paid to providers participating in Original Medicare APMs in CY 2024 by category and subcategory.

The Original Medicare results are considered interim because they are based on only three quarters of CY 2024 actual claims data. Due to claims run-out and data lag issues, each quarter of actual claims data becomes available seven to eight months after the end of the quarter.

The APMs CMS used to calculate the percent of payments made through Categories 3 and 4 of the HCPLAN APM Framework (Figure 1) in CY 2024 include shared savings, shared risk, and population-based payment models. Payment calculations include consideration of model overlap when it may be possible for beneficiaries to be enrolled in multiple models. The most recent 2024 CMS Office of the Actuary (OACT) annual total expenditures in Original Medicare data are used to calculate the denominator and is obtained directly from OACT.

Merging the Data

AHIP aggregated all submitted datasets into a unified analytical file. Merging was performed across data sources using a standardized format. The integrated dataset includes quantitative fields capturing dollars associated with HCPLAN APM Framework Categories and qualitative informational questions. A description of data elements is described below.

Data Elements

The industry-led Measurement Effort collects both quantitative and qualitative data related to APMs based on the previous calendar year or the most recent 12 months. Quantitative data focuses on the financial expenditures of health plans and FFS Medicaid states through APMs, categorized by the HCPLAN APM Framework (Figure 1). Additionally, the surveys gather insights on APM activity across health plans and payers.

APM Quantitative Data

The quantitative data collected reflects financial expenditures reported by health plans and FFS Medicaid states for payments made to providers. For purposes of the survey, the term provider means all providers for which there is health care spending, including medical, behavioral, pharmacy, and durable medical equipment, to the extent possible. Entities quantified both in- and out-of-network spending. Participants report the dollars paid in the previous calendar year or the most recent 12-month period for which data were available.

To calculate the APM metrics, health plans and states retrospectively examine the actual payments made to providers during the respective calendar year (or the most recent 12 months for which data is available) and categorize these payments according to the HCPLAN APM Framework (Figure 1).

Since most payment innovations typically incorporate multiple payment methods (e.g., FFS plus a care coordination fee and shared savings), plans and states are asked to report dollars paid according to the most dominant or advanced payment method they used (e.g., shared savings).

For a more detailed description of the total payment calculations in each category, see Table 1 below.

Table 1: 2025 APM Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2024 or most recent 12 months.	*Denominator to inform the metrics below.*
CATEGORY 1 (METRICS ARE NOT LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2024 or most recent 12 months.	Dollars under legacy payments (including fee-for-service, diagnosis-related groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2024 or most recent 12 months.
CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 2A)	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2024 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-reporting** payments (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 2B)	Dollars in pay-for-reporting programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2024 or most recent 12 months.
Total dollars paid to providers through fee-for-service plus pay-for-performance payments (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 2C)	Dollars in pay-for-performance programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2024 or most recent 12 months.
Total dollars paid in **Category 2** in CY 2024 or most recent 12 months.	Payment Reform – APMs built on fee-for-service linked to quality: Percent of total dollars paid in Category 2.

CATEGORY 3 (ALL METRICS ARE LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2024 or most recent 12 months. (Subcategory 3A)	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2024 or most recent 12 months.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2024 or most recent 12 months. (Subcategory 3A)	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2024 or most recent 12 months.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2024 or most recent 12 months. (Subcategory 3B)	Dollars in fee-for-service-based shared-risk programs: Percent of total dollars paid through fee-for-service-based shared-risk (linked to quality) payments in CY 2024 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2024 or most recent 12 months. (Subcategory 3B)	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2024 or most recent 12 months.
Total dollars paid in **Category 3** in CY 2024 or most recent 12 months.	Payment Reform – APMs built on fee-for-service architecture: Percent of total dollars paid in Category 3.

CATEGORY 4 (ALL METRICS ARE LINKED TO QUALITY)	
NUMERATOR	**DESCRIPTION OF METRIC**
Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 4A)	Condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific, population-based payments (linked to quality) in CY 2024 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 4A)	Dollars in condition-specific, bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode payments (linked to quality) in CY 2024 or most recent 12 months.

Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 4B)	Population-based payments that are not condition-specific (linked to quality): Percent of total dollars paid through population-based payments that are not condition-specific (linked to quality) in CY 2024 or most recent 12 months.
Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 4B)	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments (linked to quality) in CY 2024 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery system programs** (linked to quality) in CY 2024 or most recent 12 months. (Subcategory 4C)	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs (linked to quality) in CY 2024 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2024 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

Informational Qualitative Questions

The informational questions summarize responses from the AHIP and BCBSA surveys. The purpose is to gather opinions on current and anticipated APM activity. See Appendix A for the specific questions and response options.

2025 APM Measurement Effort Results

In the 2025 Measurement Effort, a total of 58 health plans, 2 FFS Medicaid states, and Original Medicare participated, representing 271 million people covered by an insurance plan in the commercial, Medicare Advantage, Medicaid, or Original Medicare LOBs in CY 2024. The percentage of the national market is based on a denominator of approximately million lives covered by any health insurance plan.[3]

Health plans, states, and Original Medicare reported the total dollars paid to providers through the payment methods within the subcategories according to the HCPLAN APM Framework (Figure 1). With this data, AHIP calculated aggregate results for CY 2024 by line of business and at the payment method level by category and subcategory.

[3] U.S. Census Bureau, "Health Insurance Coverage in the United States; 2025; Current Population Reports." Issued September 2025. Available at https://www2.census.gov/library/publications/2025/demo/p60-284.pdf. Accessed October 4, 2025.

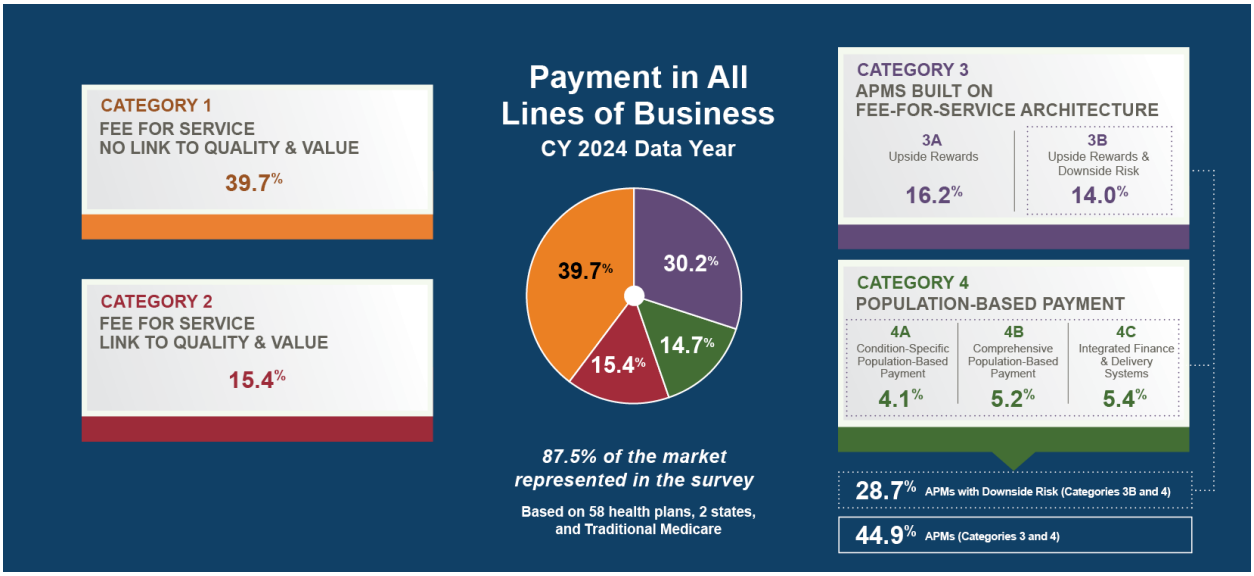
Both the AHIP and BCBSA surveys included informational questions about the future of APM adoption. This granular data provides actionable insights into the state of APMs, enriching the quantitative results with qualitative insights that identify potential future trends.

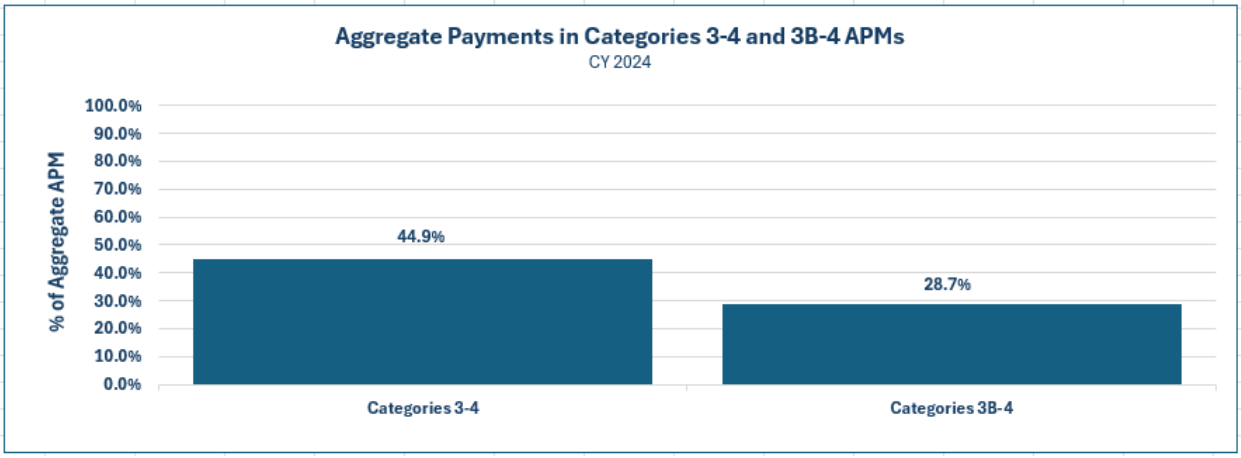
Payments Made in CY 2024

The results are shown overall and by line of business (commercial, Medicaid, Medicare Advantage, and Original Medicare) in the sections below, in alignment with the HCPLAN APM Framework (Figure 1).

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

The combined AHIP, BCBSA, and Original Medicare data, representing 87.5% of the national market in CY 2024[4] shows the following category and subcategory level payments made to providers in CY 2024 in all lines of business. In CY 2024, 44.9% of payments flowed through Categories 3 and 4 compared to 45.2% in CY 2023, and 28.7% of payments flowed through downside risk APMs categorized as 3B and above, compared to 28.5% in CY 2023.

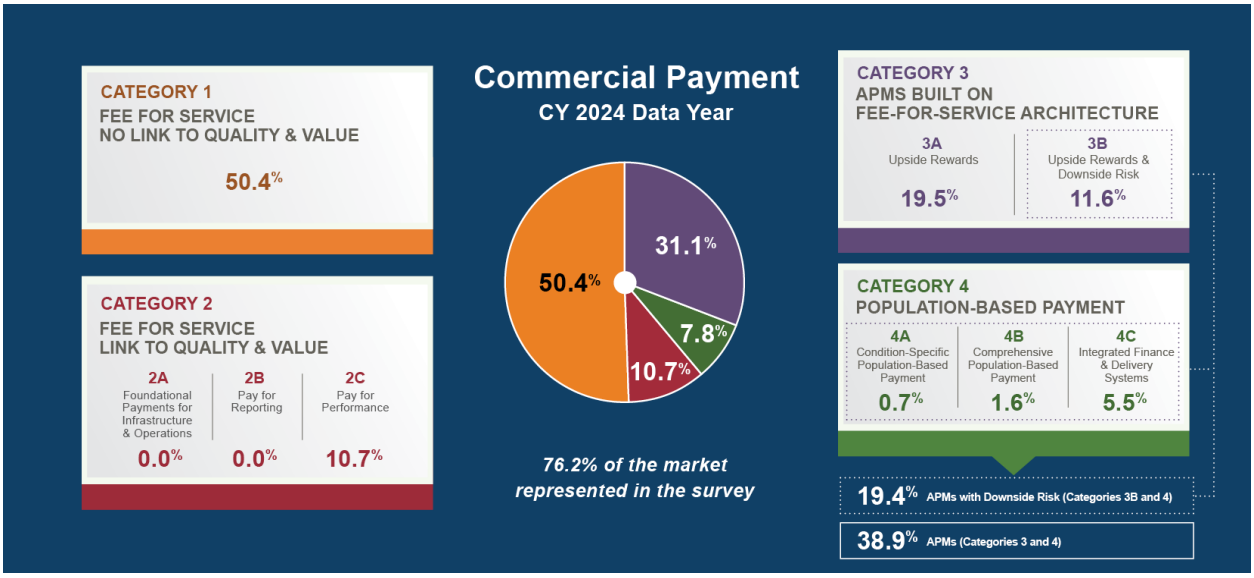


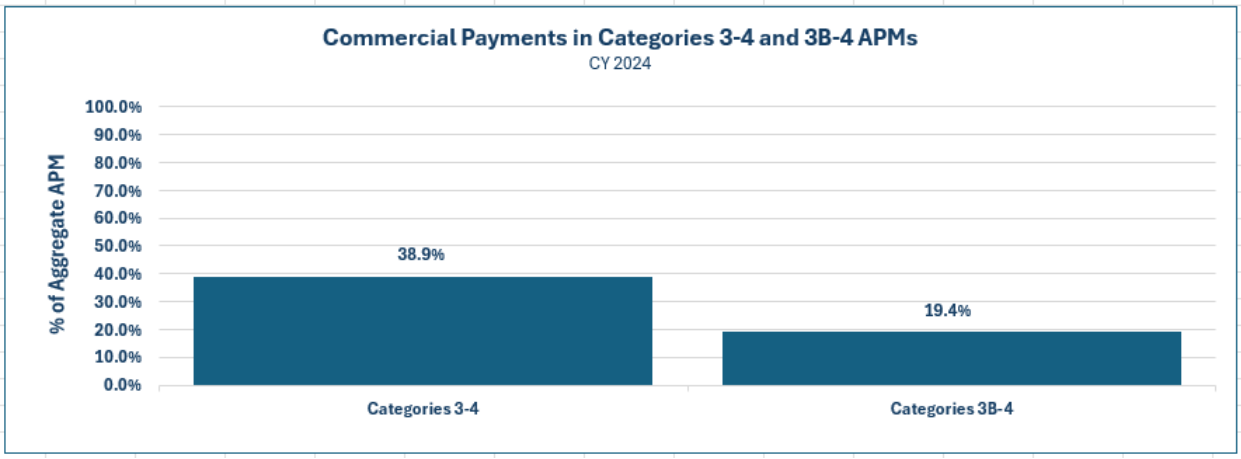


[4] 58 health plans, 2 states, Original Medicare in CY 2024.

Commercial

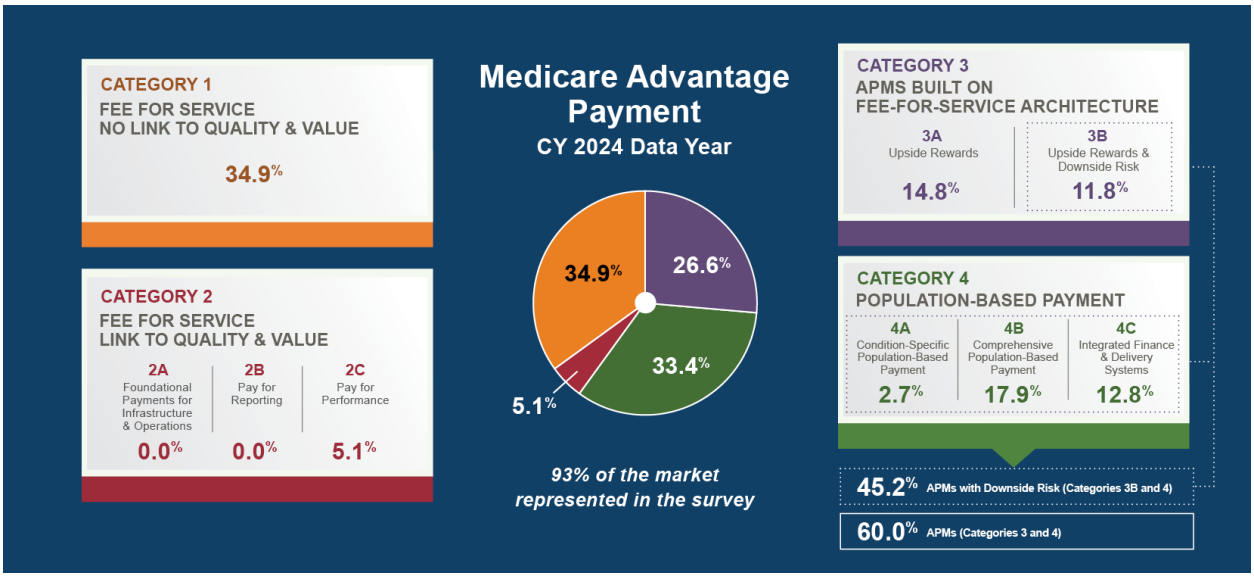
The commercial data, representing 76.2% of the national market in CY 2024, shows the following for payments made to providers in CY 2024. In CY 2024, 38.9% of payments flowed through Categories 3 and 4 compared to 39.2% in CY 2023, and 19.4% of payments flowed through downside risk APMs categorized as 3B and above, compared to 21.6% in CY 2023.

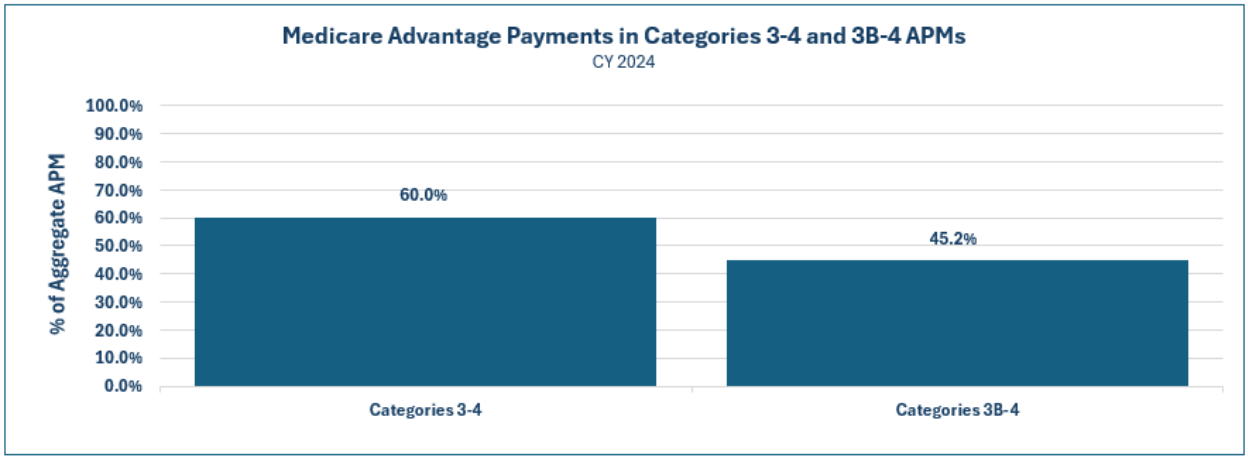




Medicare Advantage

The Medicare Advantage data, representing 93.0% of the national Medicare Advantage market *including* enrollees who are dually eligible for Medicare and Medicaid coverage in CY 2024,[5] shows the following for payments made to providers in CY 2024. In CY 2024, 60.0% of payments flowed through Categories 3 and 4 compared to 64.3% in CY 2023, and 45.2% of payments flowed through downside risk APMs categorized as 3B and above, compared to 43.0% in CY 2023

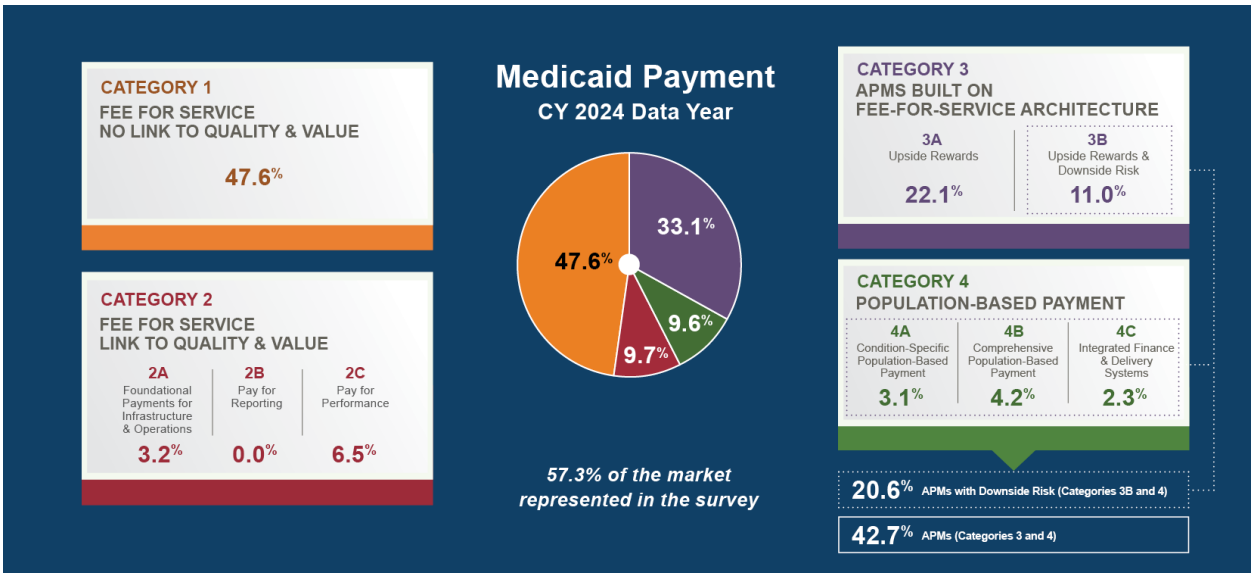


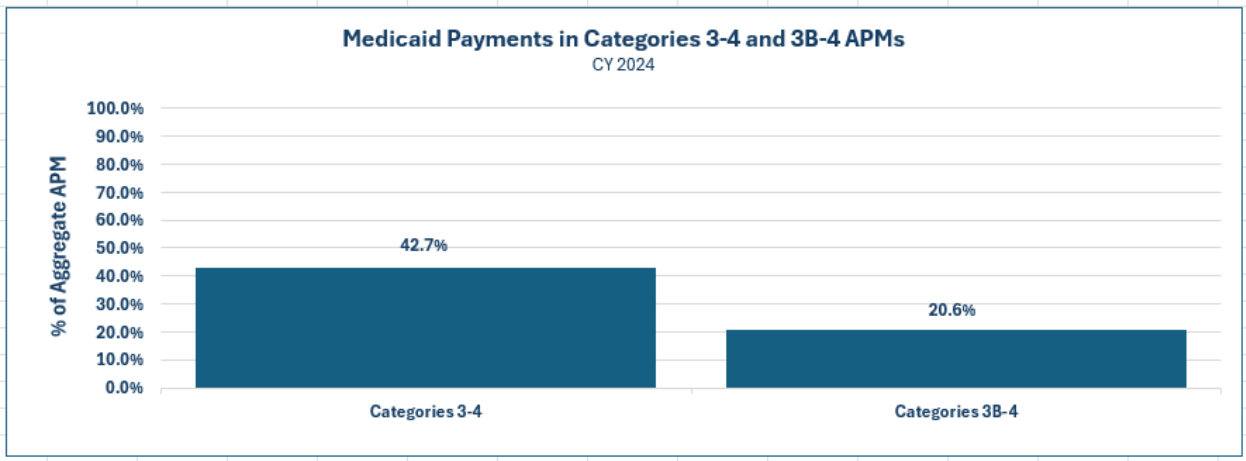


[5] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," April 2025. Available at CMS Fast Facts Accessed October 4, 2025. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," September 2024. Available at MMCO Statistical & Analytic Reports | CMS. Accessed October 4, 2025.

Medicaid

The Medicaid data, representing 57.3% of the national Medicaid market (*excluding* enrollees who are dually eligible for Medicare and Medicaid coverage) in CY 2024[6] shows the following for payments made to providers in CY 2024. In CY 2024, 42.7% of payments flowed through Categories 3 and 4 compared to 43.7% in CY 2023, and 20.6% of payments flowed through downside risk APMs categorized as 3B and above, compared to 21.1% in CY 2023.

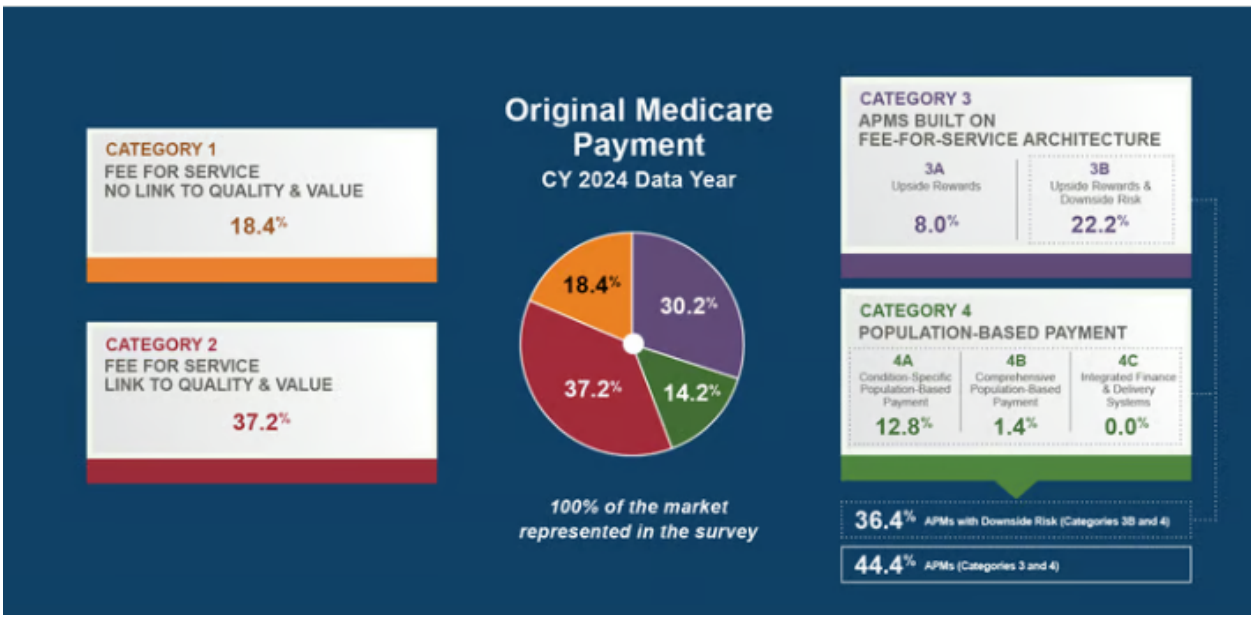


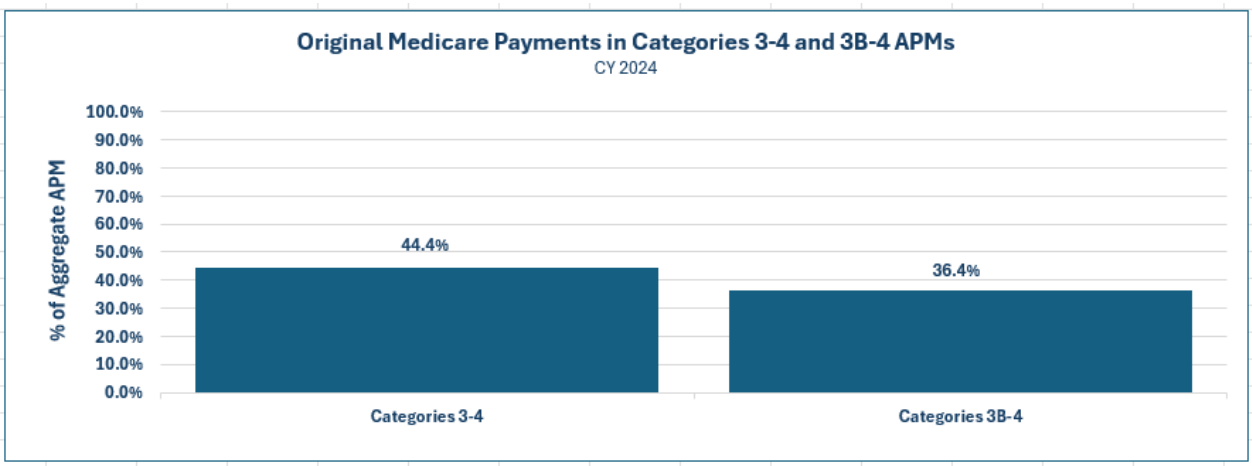


[6] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," April 2025. Available at CMS Fast Facts. Accessed October 4, 2025.

Original Medicare

The Original Medicare data, representing 33.6 million Original Medicare beneficiaries with Parts A and/or B benefits, which are 100% of the Original Medicare market,[7,8] shows the following for payments made to providers in CY 2024. In CY 2024, 44.4% of payments flowed through Categories 3 and 4 compared to 42.0% in CY 2023, and 36.4% of payments flowed through downside risk APMs categorized as 3B and above, compared to 33.7% in CY 2023.





[7] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," April 2025. Available at CMS Fast Facts. Accessed October 4, 2025.
[8] Enhancing Oncology Model expenditure data is included in the analysis.

Informational Questions

The informational questions below summarize responses combined from the AHIP and BCBSA surveys. They aimed to gather opinions on APM activity.

Table 2: Payers' Perspective Informational Questions

Payers' Perspective Informational Questions		
Payers who think APM activity:		
Will Increase		70%
Will Stay the Same		20%
Will Decrease		3%
Payers Who Are Not Sure/Declined to Respond		7%
Payers Stating that the APM Subcategory That Will Increase the Most Will Be:		
Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)		55%
Traditional shared-savings, Utilization-based shared-savings (3A)		21%
Top Three Barriers to APM Adoption as Identified by Payers		
1. Provider willingness to take on financial risk 2. Provider ability to operationalize 3. Provider interest/readiness		
Top Three Facilitators to APM Adoption as Identified by Payers		
1. Health plan interest/readiness 2. Provider interest/readiness 3. Health plan ability to operationalize		
Payers who agree or strongly agree with and payers who disagree or strongly disagree with the following: [9]	**Agree/ Strongly Agree**	**Disagree/ Strongly Disagree**
APM adoption will result in better quality of care	95%	2%
APM adoption will result in more affordable care	85%	3%

[9] The percentages for each outcome do not add up to 100% because the "not sure" and "blank/did not answer" responses were removed from the data reported here.

Payers' Perspective Informational Questions		
APM adoption will result in improved care coordination	93%	2%
APM adoption will result in more consolidation among health care providers	28%	47%
APM adoption will result in higher unit prices for discrete services	14%	47%

Limitations

Health Plan and State Participation Is Voluntary: The Measurement Effort is voluntary and did not have full participation from all eligible health plans and states, nor did it capture 100% of the lives covered by health insurance. As a result, the findings may be biased by self-selection. Health plans and states actively pursuing payment reform may have been more likely to respond to the surveys that measure APM adoption.

Different Data Sources for Denominators for each LOB: No single source captures all denominator data across LOBs. Accordingly, consistent with past practice, the aggregate denominator spanning all LOBs for this year's measurement effort is derived from multiple sources, such as the U.S. Census Bureau and CMS Fast Facts. Most notably, the aggregate all LOBs denominator, the HCPLAN historically used, and this year's industry effort used the U.S. Census Bureau, which is consistent with past practice. [10] However, combining the denominators from other sources can result in different total representativeness of the data.

Potential Variation in the Interpretation of the APM Metrics: AHIP, BCBSA, and CMS aim to facilitate consistent interpretation of the APM categories and subcategories by health plans and states responding to the survey., This includes developing precise definitions, supplying a data dictionary, hosting a training session, providing written instructions, and engaging in discussions with individual health plans and states seeking clarification. Despite these efforts, some variation in how participants interpret and apply the metrics may persist, leading to variability across data from individual health plans and states.

Data System Challenges: Some health plans and states reported data system challenges with reporting payment dollars according to the HCPLAN APM Framework (Figure 1) , because developing new system queries and sorting data according to the APM categories and subcategories is challenging. Such data system limitations can also result in health plans reporting data from an earlier 12-month period than CY 2024, which could reflect lower or higher levels of APM adoption.

[10] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2024; Current Population Reports," Issued September 2025. Available at: https://www2.census.gov/library/publications/2025/demo/p60-284.pdf. "Any Health Plan" in Table 1.

Appendix A: 2025 Measurement Effort Informational Questions

QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, what do you think will be the trend in APMs over the next 24 months?	• APM activity will increase • APM activity will stay the same • APM activity will decrease • Not sure
[To those who answered "APM activity will increase"] Which APM subcategory do you think will increase the most in activity over the next 24 months?	• Traditional shared-savings. Utilization-based shared-savings (3A) • Fee-for-service-based shared risk, Procedure-based bundled/episode payments (3B) • Condition-specific, population-based payments. Condition-specific bundled/episode payments (4A) • Population-based payments that are NOT condition-specific. Full or percent of premium population-based payments (4B) • Integrated finance and delivery programs (4C) • Not sure
[To those who answered "APM activity will decrease"] Which APM subcategory do you think will decrease the most in activity over the next 24 months?	• Traditional shared-savings. Utilization-based shared-savings (3A) • Fee-for-service-based shared risk. Procedure-based bundled/episode payments (3B) • Condition-specific population-based payments. Condition-specific bundled/episode payments (4A) • Population-based payments that are NOT condition-specific. Full or percent of premium population-based payments (4B) • Integrated finance and delivery programs (4C) • Not sure

QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, what are the top barriers to APM adoption? (Select up to 3)	• Provider interest/readiness • Health plan interest/readiness • Purchaser interest/readiness • Government influence • Provider ability to operationalize • Health plan ability to operationalize • Interoperability • Provider willingness to take on financial risk • Market factors • Other (please list)
From health plan's perspective, what are the top facilitators to APM adoption? (Select up to 3)	• Provider interest/readiness • Health plan interest/readiness • Purchaser interest/readiness • Government influence • Provider ability to operationalize • Health plan ability to operationalize • Interoperability • Provider willingness to take on financial risk • Market factors • Other (please list)
From health plan's perspective, please indicate to what extent you agree or disagree that APM adoption will result in each of the following outcomes:	• Better quality care (strongly disagree, disagree, agree, strongly agree, not sure) • More affordable care (strongly disagree, disagree, agree, strongly agree, not sure) • Improved care coordination (strongly disagree, disagree, agree, strongly agree, not sure) • More consolidation among health care providers (strongly disagree, disagree, agree, strongly agree, not sure) • Higher unit prices for discrete services (strongly disagree, disagree, agree, strongly agree, not sure)

Appendix B: Definitions

The following terms and definitions were developed to provide consistent guidance for survey respondents.

TERMS	DEFINITIONS
Alternative Payment Model (APM)	Health care payment methods that use financial incentives to promote or leverage greater value—including higher quality care at lower costs—for patients, purchasers, payers, and providers. This definition is specific to this exercise.
Appropriate care measures	Appropriate care measures are metrics that are based on evidence-based guidelines and comparative effective research. Such measures assess how well providers avoid unnecessarily costly, harmful, and unnecessary procedures. These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g., Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to, unnecessary readmissions, preventable admissions, unnecessary imaging, and appropriate medication use. Measures of appropriate care are required in order for a payment method to qualify as a Category 3 or 4 APM to ensure providers are incentivized to reduce/eliminate care that is wasteful and potentially harmful to patients. Appropriate care measures also ensure providers do not withhold necessary care and are incentivized to provide necessary care.
Category 1	 Fee-for-service with no link to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1.

TERMS	DEFINITIONS
Category 2	 Fee-for-service linked to quality. These payments utilize traditional FFS payments (i.e., payments made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.
Category 3	 APMs built on FFS architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers who meet their quality, and cost or utilization targets are eligible to share in savings, and those who do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. See definition of "appropriate care measures" for a description and examples.
Category 4	 Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.

TERMS	DEFINITIONS
Commercial Line of Business	The commercial market segment includes individual, small group, large group, fully insured, self-funded, and exchange business. To the extent a health plan provides benefits for the Federal Employee Health Benefit (FEHB) program, state active employee programs, and/or an exchange, this business is considered commercial and included in the survey. Responses to the survey data will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2024 or the most recent 12-month period for which data is available. Spending for dental and vision services are excluded.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants.
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g., diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A**]
Condition-specific population-based payment	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. [APM Framework Category **4A**]
CY 2024 or most recent 12 months	Calendar year 2024 or the most current 12-month period for which the health plan can report payment information. This is the 12-month reporting period for which the health plan should report all its "actual" spend data—a retrospective "look-back."

TERMS	DEFINITIONS
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients who are expected to have similar costs during a hospital stay—a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service (FFS)	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes, or efficiency. [APM Framework Category **1**]
Fee-For Service 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; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists. [APM Framework Category **2A**]
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g., inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B**]

TERMS	DEFINITIONS
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**]
Legacy payments	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs), and per diems. [APM Framework Category **1**]
Linked to quality	Payments that are set or adjusted based on evidence that providers meet quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet a threshold on cost and quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality" in Category 2. To qualify as a Category 3 or 4 APM, the link to quality must include “appropriate care measures.” See definition of “appropriate care measures” for a description and examples.
Medicaid Market	The Medicaid market segment includes both business with a state to provide health benefits to Medicaid-eligible individuals and state-run programs themselves. Data submitted for this survey excludes the following: health care spending for dual eligible beneficiaries, health care spending for long-term services and supports (LTSS), and spending for dental and vision services. Survey data reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2024 or the most recent 12-month period for which data is available.

TERMS	DEFINITIONS
Medicare Advantage Market	The Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it included this information in its response. Survey data reflects dollars paid for Medicare Advantage beneficiaries' (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2024 or the most recent 12-month period for which data is available. Dental and vision services are excluded.
Pay-for-performance	The use of incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. [APM Framework Categories **2C**]
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 time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could cover primary, acute, and post-acute care that is not specific to any particular condition. [APM Framework Category **4B**]
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g., hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3B**]

TERMS	DEFINITIONS
Provider	For the purposes of the APM Measurement Effort, all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible, and excludes dental and vision.
Total Dollars	The total estimated in- and out-of-network health care spend (e.g., annual payment amount) made to providers in CY 2024 or the most recent 12 months for which data is available.
Traditional shared-savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a pre-established set target for spending, as long as they meet quality targets. Traditional shared-savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. [APM Category Framework **3A**]
Utilization-based shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g., Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead, there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to, emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets. [APM Category Framework **3A**]