Office of Health Care Affordability Alternative Payment Model (APM) Standards and Adoption Goals
Last Updated: April 2025

The Office of Health Care Affordability's Mission and Purpose

In 2022, the California Health Care Quality and Affordability Act (SB 184, Chapter 47, Statutes of 2022) established the Office of Health Care Affordability (OHCA) within the Department of Health Care Access and Information (HCAI). Recognizing that health care affordability has reached a crisis point as health care costs continue to grow, OHCA's enabling statute emphasizes that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal.

Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015.[1] Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020.[2] For the fourth consecutive year, the 2024 California Health Care Foundation California Health Policy Survey reports that more than half of Californians (53%) – and nearly three-fourths (74%) of those with lower incomes (under 200% of the federal poverty level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months.[3] Among those who reported skipping or delaying care due to cost, about half reported their conditions worsened as a result. Further, high costs for health care disproportionately affect Black and Latino Californians who report they had problems paying or could not pay medical bills (40% and 36%, respectively, compared to White Californians at 25%).[3]

[1] State Health Expenditure Accounts by State of Residence, 1991-2020, Centers for Medicare & Medicaid Services. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence.
[2] Whitmore, H., & Satorius, J. (2021, August). *California Health Care Almanac, California Employer Health Benefits: Are Workers Covered?* California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2021/08/CAEmployerHealthBenefitsAlmanac2021.pdf
[3] Joynt, J., Catterson, R., & Alvarez, E. (2024, January 31). *The 2024 CHCF California Health Policy Survey.* California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2024/01/2024CHCFCAHealthPolicySurvey.pdf

OHCA has three primary responsibilities to achieve its mission of improved consumer affordability:

1. Slow health care spending growth through collection and reporting on total health care expenditure data and enforcing spending targets set by the Board.
2. Promote high-value health system performance; and
3. Assess market consolidation.

As part of its work to promote high-value health system performance, the Health Care Affordability Board approved the Alternative Payment Model (APM) Standards and Adoption Goals described below in June 2024. OHCA defines an APM as a state or nationally recognized payment approach that financially incentivizes equitable, high-quality, and cost-efficient care.[4]

Statutory Requirements

As described in the OHCA enabling statute and summarized here[5], the statutory requirements related to APMs include:

- Promote the shift from fee-for-service (FFS) payments to APMs that provide financial incentives for equitable, high-quality, and cost-efficient care.
- Convene health care entities and organize an APM workgroup.
- Set statewide goals for the adoption of APMs, measure the state's progress toward those goals, and adopt contracting standards health care entities can use.
- Set benchmarks that include, but are not limited to, increasing the percentage of total health care expenditures delivered through APMs or the percentage of membership covered by an APM.
- Require payers, fully integrated delivery systems, and restricted and limited health care service plans to submit data and other information to measure adoption of APMs.
- Data collected by OHCA to measure APM adoption may include, but is not limited to, types of payment models, adoption by line of business, the number of members covered by APMs, the percent of budget dedicated to alternative payments, or cost and quality performance measures tied to the payment models.

The OHCA enabling statute also specifies additional statutory guidance[6] for APM standards that may be used between payers and providers during contracting, as follows:

- Encourage and facilitate multi-payer participation and alignment.

[4] Health and Safety Code §127500.2 (d).
[5] These requirements are summarized from Article 5. Alternative Payment Models, Health and Safety Code §§ 127501.4(g)(1)-(2) and 127504.
[6] *See* Health and Safety Code §127504.

- Improve affordability, efficiency, equity, and quality by considering current best evidence for strategies such as quality-based or population-based payments.
- Include minimum criteria for APMs but be flexible enough to allow for innovation and evolution.
- Align with the quality and equity measures used in the OHCA quality and equity measure set to the extent possible.
- Address appropriate incentives to physicians and other providers and balancing measures, including total cost of care and quality, access, and equity to protect against perverse incentives and unintended consequences.
- Attempt to reduce administrative burden by incorporating APMs that facilitate multi-payer participation and align with other state payers and programs or national models.

The statute also requires OHCA to review the standards at least every five years to determine whether the standards are rewarding high-quality, cost-efficient, and equitable care.[7]

Background

OHCA promotes high-value system performance through its work in five focus areas: (1) primary care investment, (2) behavioral health investment, (3) APM adoption goals and standards, (4) quality and equity measurement, and (5) workforce stability. Across all these areas, the goal is to reorient the health care system towards greater value, with the vision of creating a sustainable health care system that provides high-quality, equitable care to all Californians.

OHCA launched the Investment and Payment Workgroup[8] in June 2023, bringing together stakeholders representing providers and provider organizations, academics and subject matter experts, state and private purchasers, sibling state departments, consumer advocates, patient representatives, hospitals and health systems, and health plans. The Workgroup convenes monthly to provide input as OHCA develops recommendations in the areas of APMs, primary care investment, and behavioral health investment.

OHCA presented draft recommendations for the APM Standards and Adoption Goals to the Health Care Affordability Advisory Committee on November 30, 2023, and to the Health Care Affordability Board on February 28, 2024 and May 22, 2024. Additionally, OHCA received public comment from February 28, 2024 to March 29, 2024. The APM Standards and Adoption Goals, along with supporting definitions and data collection processes, were informed by many discussions in the Investment and Payment Workgroup and incorporated feedback from various stakeholders, including sibling state departments. The APM Standards and Adoption Goals were further refined based on feedback from the Health Care Affordability Board, the Health Care Affordability

[7] *Id.*
[8] OHCA Investment and Payment Workgroup meetings and materials are publicly available.

Advisory Committee, and public comment.[9] Following this extensive engagement with a variety of stakeholders, the Board voted to approve the APM Standards and Adoption Goals on June 26, 2024.

OHCA's vision of success for the APM Standards is for stakeholders to endorse the Standards and for payers and purchasers to commit to using the Standards to guide their future contracting efforts. While OHCA will promote and monitor use of the APM Standards by contracting entities, at this time OHCA does not have standalone authority to enforce the Standards. OHCA intends for the Standards to result in greater alignment across APMs and make participation in APMs easier for payers and providers. Similarly, OHCA will partner with stakeholders to promote achievement of the APM Adoption Goals. OHCA commits to transparency and accountability by publicly reporting progress towards the stated goals. Achievement of the APM Adoption Goals and implementation of the APM Standards could be incorporated into performance improvement plans for health care entities that exceed the spending target. As APM adoption increases, health system performance should improve, leading to higher quality, more equitable, and more affordable care.

[9] Summaries of feedback from public comment, Board and Advisory Committee members, and Investment and Payment Workgroup and sibling state departments are available here: April 2024 Health Care Affordability Board Meeting, May 2024 Health Care Affordability Board Meeting, May 2024 Health Care Affordability Advisory Committee Meeting.

APM Standards for Payer-Provider Contracting (APM Standards)

The Health Care Affordability Board approved the following APM Standards. The APM Standards provide a set of ten best practices that are grounded in evidence to approach contracting decisions between payers and providers that are common across APMs.

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.[10]
2. **Implement payment models that improve affordability** for consumers and purchasers.
3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
5. **Engage a wide range of providers** by offering payment models that are fiscally feasible to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.
6. **Collect demographic data**, including race, ethnicity, language, disability status, sex, sexual orientation, and gender identity (RELD-SOGI) data, to enable stratifying performance.
7. **Measure and stratify performance** to improve population health and address inequities.
8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.
9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model.
10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

OHCA developed implementation guidance in **Appendix A** as technical assistance to support the APM Standards.

[10] Health care entities taking on a specified level of financial risk are regulated by the Department of Managed Health Care (DMHC). Compliance with these APM Standards does not obviate the need for compliance with other provisions of California law.

APM Adoption Goals

The Board approved a set of two-year goals, that differ by payer and product type, leading to a final ten-year goal for the percent of members attributed to payment models linked to quality in Health Care Payment Learning and Action Network (HCP-LAN) Categories 3 and 4 by 2034: 95% for Commercial HMO and Medicare Advantage, 75% for Medi-Cal, and 60% for Commercial PPO (see Table 1 below).

Table 1: APM Adoption Goals for Percent of Members Attributed to HCP-LAN Categories 3 and 4 by Payer and Product Type

	Commercial HMO	Commercial PPO	Medi-Cal	Medicare Advantage
2026	65%	25%	55%	55%
2028	75%	35%	60%	65%
2030	85%	45%	65%	75%
2032	90%	55%	70%	85%
2034	95%	60%	75%	95%

Rationale for the APM Adoption Goals

OHCA recommended and the Board approved the APM Adoption Goals with different ending points for different payers and product types, acknowledging that the level of APM adoption varies across the Commercial HMO, Commercial PPO, Medicare Advantage, and Medi-Cal markets in California.[11] Differences in populations, contracting challenges, regulatory requirements, and purchaser preferences contribute to this variation. These goals are more ambitious for payers and product types with greater adoption today, while allowing payers and product types with lower existing adoption levels more time to overcome challenges and strive for achievable improvement.

OHCA may consider revisions to the APM Adoption Goals after the first two years of data collection, when a baseline has been established and progress to meet the first biannual goal is evaluated.

OHCA will use the HCP-LAN framework to monitor progress towards the APM Adoption Goals.[12] The HCP-LAN framework classifies APMs into categories based on the level of clinical and financial risk taken on by a provider. The framework is used by the Centers for Medicare and Medicaid Services (CMS) to measure nationwide progress toward APM adoption, and is also used by many states, payers, and providers. Using the HCP-

[11] In the September 2023 Investment and Payment Workgroup, OHCA reviewed national and California APM adoption rates across payer type, slides 19-24.
[12] See Health Care Payment Learning and Action Network APM Framework.

LAN framework allows OHCA to compare APM adoption in California with several other states as well as national adoption levels. The APM Adoption Goals are based on the percent of members attributed to HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C arrangements. That is, only members enrolled in one of the following types of payment arrangements count toward the APM Adoption Goals:

- 3A: APMs with Shared Savings
- 3B: APMs with Shared Savings and Downside Risk
- 4A: Condition-Specific Population-Based Payment
- 4B: Comprehensive Population-Based Payment
- 4C: Integrated Finance and Delivery System

The purpose of the APM Adoption Goals is to promote a shift from fee-for-service based payments to APMs and better align financial incentives for equitable, high-quality, and cost-efficient care. OHCA focused the APM Adoption Goals on advanced APMs in Categories 3A, 3B, 4A, 4B, and 4C arrangements because these categories represent increased clinical and financial accountability for patient care while also having potential to engage a wide range of providers with varying capabilities and appetites for risk. To count towards the adoption goals, APMs must include:

1. **Meaningful Risk Sharing:** Category 3A and 3B APMs must meet a minimum threshold for shared savings or shared risk. This requirement ensures that APM arrangements built on a fee-for-service architecture have tangible financial incentives or penalties contingent upon the provider's attainment of predefined spending and quality benchmarks.[13]
2. **A Link to Quality:** Payments must be "linked to quality" such that they include potential for financial bonuses or penalties based on the provider's performance against predetermined quality benchmarks. This excludes HCP-LAN Categories 3N and 4N (risk-based payments and capitation payments that are not linked to quality). This requirement ensures that APM arrangements have a substantive connection between payments and quality outcomes.

OHCA will assess the APM Adoption Goals based on the percentage of members attributed to these advanced APMs. Focusing on percentage of members is most aligned with population health principles such that providers are accountable for all members, even those that don't seek care.[14] It encourages payers to expand or implement models that include more members and payers and providers to engage members who do not typically seek care. OHCA intends to monitor the percentage of total health care spending within each HCP-LAN category as a complementary measure.

[13] The minimum thresholds are provided in the February 28, 2023 Health Care Affordability Board Presentation – Appendix: Expanded Non-Claims Payments Framework, slides 136-139.
[14] In the October 2023 Investment and Payment Workgroup, OHCA reviewed tradeoffs for different goal metrics, slides 23-24.

OHCA will use the HCAI Expanded Non-Claims Payments Framework to collect data on APM adoption.[15] Payers will submit data according to the Expanded Non-Claims Payments Framework as part of the total health care expenditure (THCE) data collection.[16] Developed by HCAI, the Expanded Non-Claims Payments Framework organizes payments according to their purpose and provides a crosswalk to the HCP-LAN framework. OHCA will crosswalk the data after it is submitted to evaluate and publicly report on progress towards the APM Adoption Goals using HCP-LAN categories. This data collection framework is aligned with other non-claims payments data collection efforts across HCAI.

Detail about the HCAI Expanded Non-Claims Payments Framework is in **Appendix B**.

[15] Pegany S, Brandt M, Tran N, Valle M, Krawczyk C. A New Standard for Categorizing and Collecting Non-Claims Payment Data, Milbank Memorial Fund. 2024 Mar 18.
[16] On April 17, 2025, the Office of Administrative Law approved updates to OHCA's THCE data collection regulations with an immediate effective date. The updated regulations implement APM data collection informed by HCAI's Expanded Non-Claims Payments Framework.

Appendix A: Implementation Guidance for APM Standards

As technical assistance to support the APM Standards, OHCA developed implementation guidance for each standard that provides examples of specific actions health care entities can take to meet the standards. The purpose is to encourage alignment across current and future APM arrangements, not to develop standardized contract terms and language for APMs.

1. **Use prospective, budget-based, and quality-linked payment models** that improve health, affordability, and equity.[17]

   1.1. Pay providers in advance to provide a defined set of services to a population when possible. HCP-LAN classifies these models as Category 4A, 4B, and 4C.[18] Research finds that prospective payment of at least 60% of a provider organization's total payments results in meaningful change in clinical practice and reduces administrative burden.[19]

   1.2. If Category 4 payment is not feasible for a certain line of business or provider, advanced payment models that include shared savings and when appropriate, downside risk, should be used when possible. This includes models that promote higher value hospital and specialty care. HCP-LAN classifies these models as Category 3A and 3B.

   1.3. Design core model components, with input from providers, to align with models already widely adopted in California whenever possible. Examples include the Medicare Shared Savings Program (MSSP)[20] and the Realizing Equity, Access, and Community Health (REACH)[21] program. Core components should include prospective payment and attribution methodologies, benchmarking, performance measures, minimum shared savings and risk thresholds, and risk corridors. If full alignment with an existing model is not feasible, review and incorporate stakeholder perspectives and lessons learned from the CMS published reports on models.

2. **Implement payment models that improve affordability** for consumers and purchasers.

   2.1. Align financial incentives to reduce utilization and excess spend on high-cost care such as low-value specialty pharmacy, unnecessary specialty care, and avoidable emergency room and hospital care.

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[17] Health care entities taking on a specified level of financial risk are regulated by the Department of Managed Health Care (DMHC). Compliance with these APM Standards does not obviate the need for compliance with other provisions of California law.
[18] Health Care Payment Learning & Action Network (HCP-LAN) 2022
[19] Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High Levels of Capitation Payments Needed to Shift Primary Care Toward Proactive Team and Nonvisit Care. Health Aff (Millwood). 2017 Sep 1;36(9):1599-1605. doi: 10.1377/hlthaff.2017.0367. PMID: 28874487.
[20] Centers for Medicare & Medicaid Services (CMS) 2022
[21] Centers for Medicare & Medicaid Services (CMS) 2023

2.2. Create incentives to reward prevention, disease management, and evidence-based care while discouraging harmful, low value care, and over-treatment.
2.3. Reduce administrative inefficiency across the health care payment and delivery system by streamlining contracting, billing, credentialing, performance programs, and other documentation such as prior authorization.[22]
2.4. Efficiency and cost savings generated through APMs should lead to lower costs for consumers and decrease barriers to care.
2.5. Design innovative payment models to address the needs of all consumers, particularly those with the highest healthcare costs and most to gain from comprehensive, coordinated care delivery.

3. **Allocate spending upstream to primary care and other preventive services** to create lasting improvements in health, access, equity, and affordability.
   3.1. Provide sufficient primary care payment to support the adoption and maintenance of advanced primary care attributes such as primary care continuity, accessible and integrated behavioral health, and specialty care coordination.
   3.2. Facilitate equitable access to diverse, interdisciplinary care teams (e.g., Registered Nurses, Doctors of Pharmacy, and Community Health Workers, among others) to assess and address consumers' medical, behavioral, and social needs.
   3.3. Support use of technology to strengthen consumer-care team relationships, make care more accessible and convenient, and increase panel capacity without increasing provider workload.
   3.4. Encourage consumers to develop a continuous relationship with a primary care team to promote access to and use of primary care and enable payment model success.
   3.5. Reduce financial barriers for primary care services, behavioral health services, and preventive services by decreasing or eliminating out-of-pocket costs for consumers (e.g., copays, co-insurance, or deductibles in benefit design).
4. **Be transparent** with providers in all aspects of payment model design and terms including attribution and performance measurement.
   4.1. Share attribution methodologies and outputs widely and in formats accessible to providers.
   4.2. Clearly articulate the performance measures used, provide the technical specifications including risk adjustment methods, and share how incentive payments are calculated.

[22] Bentley TG, Effros RM, Palar K, Keeler EB. Waste in the U.S. Health care system: a conceptual framework. Milbank Q. 2008 Dec;86(4):629-59. doi: 10.1111/j.1468-0009.2008.00537.x. PMID: 19120983; PMCID: PMC2690367.

5. **Engage a wide range of providers** by offering payment models that are fiscally feasible to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers.

   5.1. Provide upfront financial support to new entrants to assist them in hiring care team members, improving analytic capabilities, and making other investments to foster long-term success in the model.

   5.2. Make timely incentive payments that reward improvement and attainment, ideally no later than six to nine months after the performance period.

   5.3. Give providers – particularly those with lower revenues – a gradual, stepwise approach for assuming financial risk that protects provider financial solvency and supports sustainability.

   5.4. Utilize risk adjustment methodologies that incorporate clinical diagnoses, demographic factors, and other relevant information. Monitor emerging methodologies and explore opportunities to incorporate social determinants of health in risk adjustment methodologies.

6. **Collect demographic data**, including RELD-SOGI[23] data, to enable stratifying performance.

   6.1. Participate in state and national efforts to identify and promote emerging best practices in accurate and complete health equity data collection, such as those identified in the CMS Framework for Health Equity.[24]

   6.2. Align internal RELD-SOGI data collection with the United States Core Data for Interoperability (USCDI) set where applicable and appropriate to reduce administrative burden.[25]

   6.3. Support providers in collecting information on individual consumers' social needs through standardized, validated screening tools.

   6.4. Prioritize using self-reported demographic data. When self-reported data is incomplete or unavailable, leverage population-level data or indices.

7. **Measure and stratify performance** to improve population health and address inequities.

   7.1. Select a limited number of nationally standardized measures that reflect multiple domains (e.g., quality, equity, utilization, cost, consumer experience) and populations (e.g., pediatric, adult, older adults). Prioritize outcome measures, whenever possible.

   7.2. Align measures and technical specifications with those used by the Department of Managed Health Care, California Department of Health Care Services,

[23] Race, ethnicity, language, disability status, sex, sexual orientation, and gender identity data
[24] Centers for Medicare & Medicaid Services, The CMS Framework for Health Equity (2022-2032) (2022).
[25] United States Core Data for Interoperability: Updates for Versions 2 and 3, USCDI+ 2022

Covered California, the California Public Employees' Retirement System, and the Office of Health Care Affordability, when available. In particular, include Childhood Immunization Status – Combination 10, Colorectal Cancer Screening, Controlling High Blood Pressure, Glycemic Status Assessment for Patients with Diabetes, and Depression Screening and Follow-Up for Adolescents and Adults whenever appropriate as these quality measures are the most commonly aligned across state departments.

7.3. Include measures that monitor for unintended consequences of the payment model, such as withholding appropriate, necessary care to consumers to save money. For example, track changes in potentially avoidable emergency department visits and hospital admissions.

8. **Invest in strategies to address inequities** in access, patient experience, and outcomes.

8.1. Increase payments to providers serving populations with higher health-related social needs to support enhanced medical and behavioral care and social care coordination.

8.2. Support providers in using data to identify and address inequities, including by providing care consistent with the National Culturally and Linguistically Appropriate Services Standards.[26]

8.3. Develop partnerships with community-based organizations and leverage local resources to address health-related social needs.

9. **Equip providers with accurate, actionable data** to inform population health management and enable their success in the model.

9.1. Data and information shared should reflect providers' varying analytic needs and capabilities ranging from clear actionable reports to clinical registry and claims-level data.

9.2. Offer analytic support, such as hands-on training and example dashboards, to develop the capacity of providers, interdisciplinary care teams, and non-clinical staff to ingest and benefit from information.

9.3. Facilitate data exchange across providers, community-based organizations, and payers, particularly through use of the California's Health and Human Services Data Exchange Framework.

10. **Provide technical assistance** to support new entrants and other providers in successful APM adoption.

10.1. Payers and providers should work collaboratively to develop a technical assistance plan that identifies potential barriers to success and conditions

[26] U.S. Department of Health and Human Services Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, 2013. https://thinkculturalhealth.hhs.gov/clas

necessary to build capacity in these areas. The plan should offer clear action steps for what assistance will be provided and the format and frequency of the assistance.

10.2. Technical assistance should focus on supporting providers to perform well on the metrics that impact their payment.

10.3. Develop partnerships with collaborative technical assistance organizations or other payers to collectively support technical assistance to providers.

Appendix B: HCAI Expanded Non-Claims Payments Framework

HCAI developed the Expanded Non-Claims Payments Framework (Expanded Framework) to facilitate consistent non-claims data collection for multiple HCAI use cases, including measurement towards the APM Adoption Goals, quantifying non-claims payments as part of total spending and understanding the purpose of spending, monitoring primary care and behavioral health spending, and supporting additional analyses within the Health Care Payments Data program.[27] The Expanded Framework aims to reduce the reporting burden on data submitters while increasing comparability across HCAI initiatives. HCAI developed the Expanded Framework building upon two models for categorizing alternative payment models and measuring non-claims spending – the Milbank Memorial Fund-Bailit framework and HCP-LAN framework.[28,29] The Expanded Framework payment categories and their descriptions are more specific to better capture California's unique care delivery and payment structures, such as the prevalence of professional capitation.

[27] https://hcai.ca.gov/affordability/ohca/expanded-non-claims-payments-framework/
[28] https://www.milbank.org/wp-content/uploads/2021/04/Measuring_Non-Claims_7-1.pdf
[29] Health Care Payment Learning and Action Network APM Framework

Expanded Non-Claims Payments Framework

	Expanded Non-Claims Payments Framework	Corresponding HCP-LAN Category*
A	**Population Health and Practice Infrastructure Payments**	
A1	Care management/care coordination/population health/medication reconciliation	2A
A2	Primary care and behavioral health integration	2A
A3	Social care integration	2A
A4	Practice transformation payments	2A
A5	EHR/HIT infrastructure and other data analytics payments	2A
B	**Performance Payments**	
B1	Retrospective/prospective incentive payments: pay-for-reporting	2B
B2	Retrospective/prospective incentive payments: pay-for-performance	2C
C	**Shared Savings Payments and Recoupments**	
C1	Procedure-related, episode-based payments with shared savings	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	3B, 3N
C3	Condition-related, episode-based payments with shared savings	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments	3B, 3N
C5	Risk for total cost of care (e.g., ACO) with shared savings	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	3B, 3N
D	**Capitation and Full Risk Payments**	
D1	Primary Care capitation	4A, 4N
D2	Professional capitation	4A, 4N
D3	Facility capitation	4A, 4N
D4	Behavioral Health capitation	4A, 4N
D5	Global capitation	4B, 4N
D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	4C, 4N
E	**Other Non-Claims Payments**	
F	**Pharmacy Rebates**	

*Descriptions of the corresponding HCP-LAN categories:
2A Foundational Payments for Infrastructure and Operations: Care coordination fees, payments for HIT investments
2B Pay for Reporting: Bonuses for reporting data or penalties for not reporting data
2C Pay for Performance: Bonuses for quality performance
3A Shared Savings: Shared savings with upside risk only
3B Shared Savings and Downside Risk: Episode-based payments for procedures and comprehensive payments with upside and downside risk
3N Risk Based Payments NOT Linked to Quality
4A Condition-specific Population-based Payment: Per member per month payments, payments for specialty services, such as oncology or mental health
4B Comprehensive Population-based Payment: Global budgets or full/percent of premium payments
4C Integrated Finance and Delivery Systems: Global budgets or full/percent of premium payments in integrated systems
4N Capitated Payments NOT Linked to Quality

Expanded Non-claims Payments Framework Descriptions

#	Non-claims-based Payment Categories and Subcategories	Description	Corresponding HCP-LAN Category
A	**Population Health and Infrastructure Payments**	**Prospective, non-claims payments paid to healthcare providers or organizations to support specific care delivery goals; not tied to performance metrics. Does not include costs associated with payer personnel, payer information technology systems or other internal payer expenses.**	
A1	Care management/care coordination/population health/medication reconciliation	Prospective, non-claims payments paid to healthcare providers or organizations to fund a care manager, care coordinator, or other traditionally non-billing practice team member (e.g., practice coach, patient educator, patient navigator, pharmacist, or nurse care manager) who helps providers organize clinics to function better and helps patients take charge of their health.	2A
A2	Primary care and behavioral health integration	Prospective, non-claims payments paid to healthcare providers or organizations to fund integration of primary care and behavioral health and related services that are not typically reimbursed through claims (e.g., funding behavioral health services not traditionally covered with a fee-for-service payment when provided in a primary care setting). Examples of these services include a) substance use disorder or depression screening, b) performing assessment, referral, and warm hand-off to a behavioral health clinician, c) supporting health behavior change, such as diet and exercise for managing pre-diabetes risk, d) brief interventions with a social worker or other behavioral health clinician not reimbursed via claims.	2A
A3	Social care integration	Prospective, non-claims payments paid to healthcare providers or organizations to support screening for health-related social needs, connections to social services and other interventions to address patients' social needs, such as housing or food insecurity, that are not typically reimbursed through claims.	2A
A4	Practice transformation payments	Prospective, non-claims payments paid to healthcare providers or organizations to support practice transformation which may include care team members not typically reimbursed by claims, technical assistance and training, and analytics.	2A

A5	EHR/HIT infrastructure and other data analytics payments	Prospective, non-claims payments paid to healthcare providers or organizations to support providers in adopting and utilizing health information technology, such as electronic medical records and health information exchanges, software that enables practices to analyze quality and/or costs, and/or the cost of a data analyst to support practices.	2A
B	**Performance Payments**	**Non-claims bonus payments paid to healthcare providers or organizations for reporting data or achieving specific goals for quality, cost reduction, equity, or another performance achievement domain.**	
B1	Pay-for-reporting payment	Non-claims bonus payments paid to healthcare providers or organizations for reporting data related to quality, cost reduction, equity, or another performance achievement domain.	2B
B2	Pay-for-performance payments	Non-claims bonus payments paid to healthcare providers or organizations for achieving specific, predefined goals for quality, cost reduction, equity, or another performance achievement domain.	2C
C	**Shared Savings Payments and Recoupments**	**Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) based on performance relative to a defined spending target. Shared savings payments and recoupments can be associated with different types of budgets, including but not limited to episode of care and total cost of care. Dollars reported in this category should reflect only the non-claims shared savings payment or recoupment, not the fee-for-service component. Recouped dollars should be reported as a negative value. Payments in this category may be considered "linked to quality" if the shared savings payment or any other component of the provider's payment was adjusted based on specific predefined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the shared savings payment, then the shared savings payment would be considered "linked to quality." Payments in this category may not be "linked to quality".**	

C1	Procedure-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A, 3N
C2	Procedure-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a procedure-based episode (e.g., joint replacement). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3B, 3N
C3	Condition-related, episode-based payments with shared savings	Non-claims payments to healthcare providers or organizations for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	3A, 3N
C4	Condition-related, episode-based payments with risk of recoupments	Non-claims payments to healthcare providers or organizations (or recouped from healthcare providers or organizations) for a condition-based episode (e.g., diabetes). Under these payments, a provider may earn shared savings based on performance relative to a defined spending target for the episode. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models	3B, 3N

		in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory.	
C5	Risk for total cost of care (e.g., ACO) with shared savings	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. Under this type of payment, there is no risk of the payer recouping a portion of the initial fee-for-service payment if the defined spending target is not met. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 40% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 20% if they do not meet minimum savings requirements.	3A, 3N
C6	Risk for total cost of care (e.g., ACO) with risk of recoupments	Payment models in which the provider may earn a non-claims payment, often referred to as shared savings, based on performance relative to a defined total cost of care spending target. If the defined spending target is not met, the payer may recoup a portion of the initial fee-for-service payment. Payment models in this subcategory should be based on a fee-for-service architecture. Payment models paid predominantly via capitation should be classified under the appropriate "Capitation and Full Risk Payment" subcategory. These models must offer providers a minimum of 50% shared savings if quality performance and other terms are met. Models offering a lessor percentage of shared savings are classified as “Performance Payments.” Providers that would be classified by CMS as “low revenue” may be eligible for shared savings at a lower rate of 25% if they do not meet minimum shared savings requirements. These models also must put providers at risk for at least 30% of losses. Models offering less than this degree of risk are classified as “Risk for total cost of care with shared savings.”	3B, 3N

D	**Capitation and Full Risk Payments**	**Per capita, non-claims payments paid to healthcare providers or organizations to provide a defined set of services to a designated population of patients over a defined period of time. Payments in this category may be considered "linked to quality" if the capitation payment or any other component of the provider's payment was adjusted based on specific, pre-defined goals for quality. For example, if the provider received a performance payment in recognition of quality performance in addition to the capitation payment, then the capitation payment would be considered "linked to quality." Payments in this category may not be "linked to quality".**	
D1	Primary Care Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide primary care services to a designated patient population over a defined period of time. Services are restricted to primary care services performed by primary care teams.	4A, 4N
D2	Professional Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide professional services to a designated patient population over a defined period of time. Services typically include primary care clinician, specialty care physician services, and other professional and ancillary services.	4A, 4N
D3	Facility Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide inpatient and outpatient facility services to a designated patient population over a defined period of time.	4A, 4N
D4	Behavioral Health Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide behavioral health services to a designated patient population over a defined period of time. May include professional, facility, and/or residential services.	4A, 4N
D5	Global Capitation	Per capita, non-claims payments paid to healthcare organizations or providers to provide comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital, and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out.	4B, 4N

D6	Payments to Integrated, Comprehensive Payment and Delivery Systems	Per capita, non-claims payments paid to healthcare organizations and providers to provide a comprehensive set of services to a designated patient population over a defined period of time. Services typically include primary care, specialty care, other professional and ancillary, inpatient hospital and outpatient hospital at a minimum. Certain services such as behavioral health or pharmacy may be carved out. This category differs from the global capitation category because the provider organization and the payer organization are a single, integrated entity.	4C, 4N
E	**Other Non-Claims Payments**	**Any other payments to a healthcare provider or organization not made on the basis of a claim for health care benefits and/or services that cannot be properly classified elsewhere. This may include retroactive denials, overpayments, and payments made as the result of an audit.**	
F	**Pharmacy Rebates**	**Payments, regardless of how categorized, paid by the pharmaceutical manufacturer or pharmacy benefits manager (PBM) to a payer or fully integrated delivery system.**	