LAN PAYMENT ARRANGEMENT CATEGORIES

Health Care Payment Learning & Action Network. Alternative Payment Models APM Framework.

Category Code	Value	Definition/Example
01	**Fee for Service**	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis- related groups (DRGs) that are not linked to quality are included in Category 1.
2A	**Foundational Payments for Infrastructure and Operations**	Payments for infrastructure investments that can improve the quality of patients care (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
2B	**Pay for Reporting**	Payments (incentives or penalties) to report quality measurement results.
2C	**Pay-for-Performance**	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance).
3A	**APMs with SharedSavings**	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met (e.g., shared savings with upside risk only).
3B	**APMs with Shared Savings and DownsideRisk**	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk).
3N	**Risk Based PaymentsNOT Linked to Quality**	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets).
4A	**Condition-Specific Population-Based Payment**	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).
4B	**Comprehensive Population-BasedPayment**	Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments).

Category Code	Value	Definition/Example
4C	**Integrated Finance and Delivery System**	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systemsthat offer their own insurance products (e.g. global budgets or full/percent of premium payments in integrated systems)
4N	**Capitated Payments NOT linked to Quality**	Payments that are prospective and population-based, but not linked to quality.

For more information about this report, please contact us at info@civhc.org