APM Roles & Responsibilities Matrix
Resource Guide

About the Resource

The Health Care Transformation Task Force developed the Alternative Payment Model (APM) roles and responsibilities matrix as a resource to support payer, provider, and purchaser efforts to clearly identify and assign roles and responsibilities for common APM work streams and activities. This resource is intended for use by two or more entities working under an existing APM contract, though it could also be used to help define roles and responsibilities while designing a new APM arrangement or partnership. The resource is built in the format of a "RACI" matrix and is pre-populated with common workstreams and activities appropriate for implementing APMs. Users of the resource may choose to retain the existing list of activities or modify it to fit their specific needs. The goal of completing a RACI matrix is to clearly identify the relationships between parties working on a project in order to recognize gaps or overlaps in responsibilities, improve efficiencies and communication, and promote successful APM operations.

About us

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. The Task Force is committed to rapid, measurable change, both for itself and the country. It aspires to have 75 percent of its members' business operating under value-based payment arrangements by 2020.

Contact info@hcttf.org with any questions or feedback about this resource.

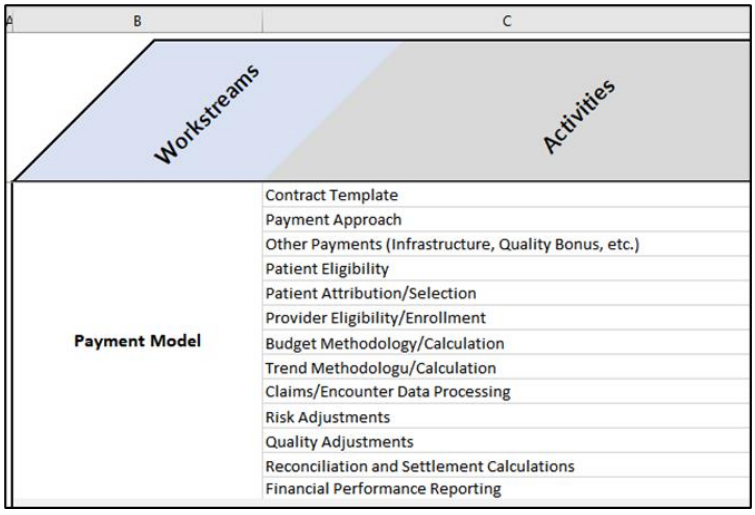
A. What is a RACI Matrix?

RACI is an acronym for **R**esponsible, **A**ccountable, **C**onsulted, and **I**nformed. A RACI matrix is a workload analysis tool that allows a user to organize and visualize the specific workstreams and activities associated with a project and the individuals or organizations that are involved in each activity. These individuals or organizations are assigned one of four roles for each activity:

- **Responsible:** The entity that is tasked with performing or completing the activity. This role can be held by one or multiple entities for a given activity.
- **Accountable:** The entity that is the ultimate authority or owner of the activity. This role approves an activity or determines when it is complete. There should generally be only one accountable entity per activity.
- **Consulted:** An entity that needs to review and provide input on an activity before it is finalized. This role can be held by multiple entities.
- **Informed:** An entity that should be provided informational updates but does not need to contribute to or provide input on an activity.

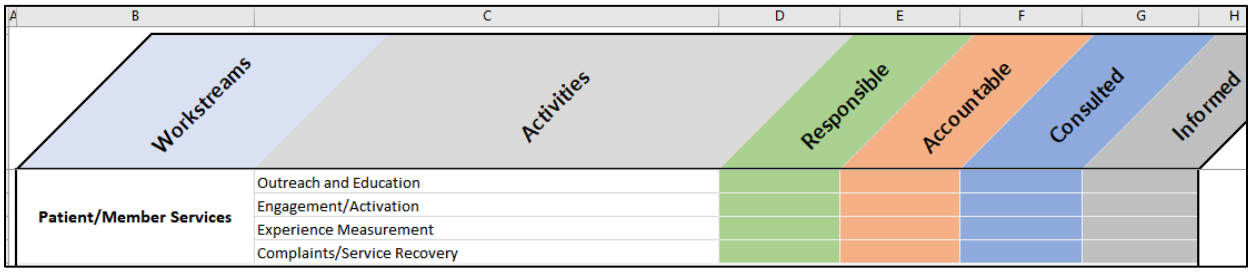
B. How to Use the Matrix Resource

This APM Roles and Responsibilities Matrix resource serves as a general framework to inform provider, payers, and purchaser efforts to develop and implement successful APMs. Traditionally, the development of a RACI matric starts with identifying and listing all the work streams and activities necessary to complete a given project on the vertical axis of a table. To jumpstart this process, we have prepopulated the matrix with common APM workstreams (in column B) and activities (in column C). Additional information on the activities and workstreams can be found in Section D of this document.



	B	C
	Workstreams	Activities
	Payment Model	Contract Template
		Payment Approach
		Other Payments (Infrastructure, Quality Bonus, etc.)
		Patient Eligibility
		Patient Attribution/Selection
		Provider Eligibility/Enrollment
		Budget Methodology/Calculation
		Trend Methodologu/Calculation
		Claims/Encounter Data Processing
		Risk Adjustments
		Quality Adjustments
		Reconciliation and Settlement Calculations
		Financial Performance Reporting

The next step in RACI development is to identify all the stakeholders involved in the project and engage them in discussion to define the roles that each party is expected to play and how those roles related to each other. Columns D through G contain blank spaces for users to assign stakeholders to the responsible, accountable, consulted, and informed roles for each activity.



Tips for Success:
1. Every activity should have at least one stakeholder that is responsible for completing the activity, some activities may have more than one responsible party.
2. None of the activities should have more than one accountable party.
3. The consulted and informed roles may or may not be applicable to your project depending on the stakeholders you are working with.
4. Review the completed matrix to identify workload imbalances and discuss options for balancing accountable and responsible roles across parties.

C. Customizing the Resource

The resource is designed in Microsoft Excel to allow users to download and modify the table to fit their specific needs. Users are encouraged to insert additional rows and columns as desired to customize the resource to their specific objectives or integrate the workstreams and activities columns into existing planning resources. Options for customizing the resource in Excel include, but are not limited to:

- Adding new columns to capture:
    - Workstream and activity timelines, milestones, and deliverables
    - Activity status (behind schedule, on time, ahead of schedule)
    - Resource requirements for completion
    - Barriers and threats to successful operations

- Adding additional rows to capture:
    - New workstreams or activities
    - Information defining planning vs. operations actions for each activity
    - More detailed information on the prerequisites or component steps to complete a given activity

- Creating new Excel sheets to:
    - Cross link and isolate individual workstreams from the main sheet to simplify review and communication with parties focused solely on activities in that area
    - Break out individual workstreams and create space for more detailed activities and status monitoring
    - Develop linked workstream matrices that each party can customize to reflect their organizations processes while maintaining a single master sheet all parties can reference.

D. Workstream and Activity Descriptions

The Roles and Responsibilities Matrix is divided into seven separate workstreams that are generally required for APMs. These workstreams are further separated into constituent activities commonly performed by payers, providers, and purchasers. It is important to note that this is not comprehensive list of all potential workstreams and activities, rather it represents common elements found in most APMs. Users are encouraged to customize the resource by adding or deleting elements to reflect their APM arrangements. Users may also consider using this resource to complement existing project planning resources or as a guide to facilitate discussions with organizations they are partnering with.

The specific workstreams and activities are:

Payment Model

The payment model workstream is focused on the design and operation of APMs. Common activities covered under this workstream include:

- **Contract Template**: The boilerplate language that serves as the foundation for the negotiation of the APM relationship between a payer and provider. Contracting provisions may include details like the length of a contract agreement, the terms for renewal of the contract, data reporting, care management, quality measurement requirements, and procedures for termination of the contract.
- **Payment Approach:** Key details regarding how providers are paid including payment triggers, timing, and manner of payments. Common APM payment approaches include episodes of care, risk arrangements built on fee-for-service (FFS), and models built on partial or fully capitated payments. Payment methodologies may also incorporate provisions that support the transition from FFS to an APM payment model as providers are able to accept increasing levels of risk.
- **Other Payments**: Managing non-clinical payments such as infrastructure investments, quality bonus payments, and other investments. The details of these payments are typically defined within an APM contract but may also be implemented on an ongoing basis in response to specific provider needs or to address extreme and unusual circumstances.

- **Patient Eligibility:** This activity covers the design and implementation of a methodology for determining what patients are eligible to be included or excluded from a given APM. Factors impacting eligibility may include patient demographics, specific service needs, or existing conditions that impact a patient's suitability for a specific model.
- **Patient Attribution/Selection**: These activities include developing and implementing a methodology for how provider responsibility for patients is decided. This can be done through a variety of mechanisms including the direct selection of a provider by a patient, the use of claims data to identify the provider that delivered a majority or plurality of care, or through the delivery of a specific triggering service or inpatient admission.
- **Provider Eligibility/Enrollment**: Eligibility and enrollment activities require managing the process for determining which organizations and/or individual providers are eligible to participate in an APM and, if necessary, enrolling them into the model as a formal participant. This may involve APM participants submitting lists of TINs, TIN/NPI combinations, or the establishment of new legal entities to operate the model.
- **Budget Methodology/Calculation**: This activity sets the spending expectations for an APM. Successful model implementation hinges on providers and payers having a clear understanding of the methodology for determining financial performance under an APM and agreement on how budget is calculated.
- **Trend Methodology/Calculation**: APM budgets require ongoing adjustments to account for changes in price and service utilization trends. As with the budget calculation it is critical that payers and providers have a mutual agreed upon understanding of the factors that influence these calculations.
- **Claims/Encounter Data Processing**: Activities related to receiving, processing, and paying claims. These activities are traditionally conducted by payers but, under some APMs, the provider may take over accountability for claims processing. APMs may also be designed to eliminate claims processing all together, however, these models still require the submission of patient encounter data used to track service utilization, make quality adjustments, and perform risk adjustment among other activities.
- **Risk Adjustment**: Risk adjustment is key for creating a fair playing field for providers participating in APMs. It increases the chances that a participant's performance under an APM is due efforts to improve clinical care rather than the underlying characteristics of a patient population. Risk factors may include patient diagnosis, underlying conditions, and demographic factors such as age, race, and sex.
- **Quality Adjustment**: Quality adjustments, like risk adjustments, should promote a level playing field for APM participants and should also create incentive for improving the quality of care. These adjustments may be based on process or outcome measures and are often factored into either payment bonuses/penalties, or updates to future budgets.
- **Reconciliation and Settlement Calculations**: These activities include the establishment of 1) a methodology for calculating actual spending against the allowed spending under the APM to determine a provider's overall performance under the model and 2) issuing interim and final payments to providers.

- **Financial Performance Reporting**: Successful APM participation requires model participants have access to the data necessary to manage risk and track financial performance. It is generally a payer task to aggregate both provider and network financial performance information and make it available to model participants.

Benefit Design

The benefit design workstream is typically the shared responsibility of payers and purchasers. Under APM arrangements, payers and purchasers may also want to engage providers to determine what services will add the most value in terms of improving care and reducing costs. This workstream includes the following activities:

- **Benefit Coverage:** Establishing the set of covered and non-covered benefits for an insurance product. The determination of what services are covered vs. not covered is often up to payers to establish; however, purchasers also play a significant role in driving these decisions.
- **Cost Sharing:** This activity covers determination related to patient/member liability for insurance products such as deductibles, co-pays, and out of pocket maximums. APMs typically modify or eliminate many forms of cost sharing for preventative and high-value services.
- **Member Incentives:** Payers, providers, and purchasers may all choose to develop of incentives to encourage specific member/patient behaviors. These activities create ample opportunity for overlap in incentive structures and goals.

Patient/Member Services

The patient and member services workstream encompasses a range of activities that often require ongoing coordination and cooperation between payers, providers, and purchasers. These activities include:

- **Outreach and Education:** Outreach and education activities are often conducted by payers, providers, and purchasers for varying reasons. It is not uncommon for patients/members to be contacted by multiple parties for the same (or substantially similar) outreach and education goals.
- **Engagement/Activation:** Patient engagement and activation activities are typically health care provider led activity intended to improve patient care experiences and outcomes. Payers and purchasers may also have efforts designed to promote engagement and activation for their members/employees.
- **Experience Measurement:** The collection and reporting of patient experience data, often via standardized surveys, is normally an activity conducted by both payers and providers.
- **Complaints/Service Recovery:** Responding to patient/member concerns is a standard activity for both payers and providers and an area that can generate overlap in responsibilities.

Clinical Care Delivery

The clinical care delivery workstream encompasses the activities that are related to the provision of services to patients. These activities include:

- **Patient Roster/Empanelment:** This activity area involves the assignment of patients to a specific practice or individual provider. It is a foundational activity critical for creating provider and care team accountability for the management of a patient's health.
- **Risk Assessments:** Providers, payers, and purchasers commonly use risk assessments (health and clinical) to inform decision making. This may include decisions around benefit design, treatment options for specific conditions, the identification of social needs, and the development of wellness programs.
- **Care Coordination/Case Management:** Care coordination and case management activities aim to assist patients in navigating the health care system, ensuring their information and care needs are coordinated and managing chronic or complex conditions. Both providers and payers frequently operation coordination and management programs for their patients/members. Overlapping coordination and management efforts are a common area of concern due to the potential to create confusion and frustration for patients.
- **Population Health:** Population health related activities include the identification of gaps in care at the population level and actions to address those gaps. As with care coordination and case management, these activities are often conducted by both providers and payers and present opportunities for coordination.
- **Patient Access/Enabling Services:** Ensuring patients have access to the care they need as well as the knowledge and ability to manage their health conditions is a role that both providers and payers may attempt to fill in different ways.
- **Service Delivery:** The delivery of health care services to patients is generally an activity that is led by providers.
- **Staffing/Training:** Hiring, training, and managing staff responsible for clinical care delivery is a role filled by providers or an entity that providers contract with.
- **Utilization Management:** Utilization management activities such as prior authorization, and referral management, are common features of FFS payment arrangements intended to manage the services and spending from a patient population. Under APMs utilization management can be reduced or eliminated commensurate with the level of risk participants accept under the model.
- **Provider Credentialing and Privileging:** Verifying provider qualifications and approving a provider to perform within a specific scope of practice are activities are managed at the provider level.

Health Related Social Needs

This workstream includes activities that relate to the assessment and improvement of the health status for a specific population. The population may be defined at a clinical, or geographic level.

- **Community Needs Assessments:** Conducting assessments to identify the existing resources, needs, and strengths of a community is a task that is often driven by local public health or other government agencies; however, health care providers often play a role in these efforts. The adoption of APMs that focus on population health further increase the importance of this activity and create incentives for payers, providers, and purchasers to focus attention on needs assessments.
- **Social Needs Assessments:** Assessing a patient's social needs is an activity that is not uniformly done in health care but is becoming more common as payment models change and both providers and payers recognize the importance of social determinants of health on health care outcomes and cost. When done, these assessments are typically integrated into provider interactions with patients; however, payers and purchasers may also engage in this area.
- **Referral for Service/Closing Gaps:** This activity involves connecting a patient to the services necessary to address an identified need or gap in care. This may involve direct provision of services or referral to an outside organization.
- **Follow-Up:** The follow-up activity involves closing the loop with patients and service providers to determine if the need or gap has been met.

Health IT/Data Sharing

The health IT and data sharing workstream includes activities related to the collection and management data for care delivery, coordination activities, and (more recently) the collection of data on the social needs and risk factors for individuals and communities. These activities include:

- **EMR/EHR Management:** Electronic medical records and electronic health records are key infrastructure that enables data collection to support the care coordination, case management, and quality measurement activities essential to successful APM arrangements.
- **Electronic Resources (Clinical Decision Support, Referral):** Electronic resources such as clinical decision support systems and electronic referrals assist providers in delivering evidence-based care, connecting patients to needed services, and improving overall care quality. The selection of these resources is generally the responsibility of providers.
- **Health Information Exchange:** Health information exchange systems allow providers, patients, and payers to securely exchange health care information. These systems may be operating by payers, providers, states, or third-party companies. While the responsibility for operating an HIE varies, all the parties exchanging data within the system have a role to play in submitting data and determining how it is used.
- **Clinical Data Reporting:** Clinical data collection and reporting is driven by the activities and services of providers and is generally captured in an EHR or EMR.
- **Claims/Encounter Data Reporting:** Claims and encounter data are generated from the information gathered when providers deliver services to patients. Depending on the APM arrangement, providers may submit this data to payers for reimbursement or simply for record keeping and data analysis. Processing these data and generating reports on service

utilization, spending, and quality are critical for APM participants to manage risk and success under an APM arrangement. The data must be clean and useable by the provider.

- **Social Needs Data Reporting:** Payers, providers, and purchasers are increasingly interested in data on patients' social needs. This information can come from a variety of sources including screenings in clinical settings, payer and purchaser assessments, population level surveys, and administrative data from social service providers.
- **Data Analytics:** Analyzing data to generate useful reports, identify trends, and inform quality improvement initiatives. Depending on the capabilities of the provider this may involve payer generated standard reports or provider led analysis using raw data files.

Quality Strategy

The quality strategy workstream covers activities focused on ensuring that the incentives built into an APM improve the quality of care delivered to patients and do not result in unintended negative consequences for patient care. Activities in this workstream include:

- **Measure Selection:** Quality measure selection is a central component of all APMs and serves as both an incentive to promote ongoing quality improvement and a guardrail against unintended consequences that could harm patients. The selection of quality measures for an APM is typically done during the APM design phase; however, measure strategies may be updated or modified over the life of a model.
- **Target Setting:** Establishing quality targets is a key component of APM model design. Quality targets are used to both help guard against unintended negative impacts on the quality of care and provide incentives for providers to focus on maintaining or improving key quality metrics.
- **Quality Data Reporting:** The collection and reporting of quality data is a foundational element to the operation of APMs. These measures may include elements such as clinical data, patient reported outcomes, and claims data indicating services delivered. The collection and reporting of quality measures is often a shared responsibility that may fall to payers or providers depending on the source of the data.
- **Analysis/Score Calculation:** The quality measure data must be aggregated, analyzed, and risk adjusted to develop quality performance scores for APM participants. The analysis of quality measure data and calculation of final performance scores under an APM is generally a payer led activity done in coordination with providers.
- **Final Performance Reports:** As with the calculation of quality scores, the development of final performance reports is typically a payer task. These reports are sent to providers for their review and approval or for further discussion about the report findings.
- **Quality Improvement Initiatives:** Translating quality performance measurement into improvement initiatives is an activity that often occurs at both the payer and provider level. Purchasers may also operate improvement initiatives to address quality issues identified in the care their employees receive.

Payer-Provider Engagement

The payer-provider engagement workstream focuses on payer and provider relationship development and the activities related to practice transformation and shared infrastructure. Activities in this workstream include:

- **Governance/Meeting Structure:** Successful APM implementation requires a higher degree of coordination between payers and providers. This coordination generally includes establishing a governance structure with regular meetings to review policy and operations issues.
- **Payer Supports:** Under APM contracts payers may extend support to practices to enable the transition away from FFS and improve care quality. These supports may include assessments of infrastructure needs, technical assistance with data analytics, population management, and practice transformation investments.
- **Shared Resources:** This activity covers situations where payers and providers identify situations where coordinating and sharing resources to accomplish a given task is more effective than making individual investments.