APM Metric Overview

This information request involves collecting information from commercial, Medicaid, and Medicare Advantage health plans to track the adoption of alternative payment models (APMs). This information will help the current and future LAN audience understand general market trends and the pace of progress toward alternative payment model adoption across public and private health plans. The LAN adapted the CMS payment taxonomy and expanded it by introducing refinements that describe health care payment through the stages of transition from pure fee-for-service toward APMs that tie payment to cost and quality. The original APM Framework, published in January 2016, classifies payment models into four categories:

- Category 1—fee-for-service with no link of payment to quality
- Category 2—fee-for-service with a link of payment to quality
- Category 3—alternative payment models built on fee-for-service architecture
- Category 4—population-based payment

The LAN's goal is to bring together private health plans, providers, employers, state partners, consumer groups, individual consumers, and other stakeholders to accelerate the transition to alternative payment models. Spending through APMs will be calculated in the following manner:

Denominator: Participating health plans will report the total estimated in- and out-of-network health care spend (e.g. annual payment amount) made to providers in calendar year (CY) 2016 or most recent 12 months.

Numerator: The numerators will generally track to the subcategories and models listed in the original APM Framework. Health plans will report the total estimated payment amounts of categories 1 through 4 payments made to providers in CY 2016 or most recent 12 months.

Targeted Respondents

In order for this effort to yield a meaningful representation of the private insurance market, we are targeting major health plans that represent greater than 67% of covered lives across the commercial, Medicare Advantage and Medicaid markets. The LAN is recruiting health plans to participate directly as well as partnering with trade associations, some of which will share their members' aggregate results with the LAN.

The LAN strives to broaden its reach by increasing the number of health plans participating in the LAN who are committed to: 1) implementing APMs and 2) submitting data that, when aggregated with others', will categorize how health plans are paying providers on a national scale. Given health plan involvement in the LAN events to date (estimated at over 250 organizations), and the strong participation in the LAN's 2016 APM Measurement Effort which represented 67% of covered lives in three market segments, we believe that a sufficient number of health plans will participate in the 2017 APM Measurement Effort so that the resulting data will give a strong indication of the national direction.

Neither a census nor a nationally representative sample is necessary for the purposes of this data collection effort. Rather, we have identified a minimum proportion of the market share (i.e., 60 percent of covered lives) and include as many health plans as are necessary to reach that threshold. In effect, this will require recruiting health plans across a variety of regions and states, yielding a cohort of health plans that covers much of the U.S. market. For instance, in addition to the very large national insurance companies (Anthem, United Healthcare, Aetna, Cigna and Humana), we are targeting state-based insurers like the Blue Cross Blue Shield plans in many states. In addition, we are working in conjunction with major health plan associations including America's Health Insurance Plans (AHIP), the Blue Cross and Blue Shield Association (BCBSA), Association for Community Affiliated Plans (ACAP) and National Association of Medicaid Directors (NAMD).

APM Data Collection & Reporting

For data collection, we will provide participating health plans with Excel workbooks for each of the commercial, Medicaid, and/or Medicare Advantage lines of business in which they are involved. Health plans will respond to one or more workbooks, depending on their lines of business. The workbooks will contain specific instructions for each metric, including the number of beneficiaries involved in APM programs, total spending in these APM programs, and the payer's overall health care spending in- and out-of-network (i.e., the "denominator") for each line of business. Health plans are instructed to also provide their in-network only health care spending. This will be used as an alternative denominator for comparison purposes. After the health plans submit these data, a cross checking of responses will help to identify whether any data appear to be outliers and require correction. We will aggregate all data submitted which, together with aggregated data from the trade associations, will quantify the dollars flowing through the categories and subcategories specified in the Framework.

At the end of each data collection and after aggregation and analysis, the LAN plans to report that X # of health plans participated in the data collection, X # of health plans represent Y beneficiaries, which is Z% of the total covered life population within a given calendar year. Among this proportion, A% of payment is in category 1, B% in category 2, and C% in a combination of category 3 and category 4.