2018 National 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 APM adoption across public and private payers. The LAN adapted the Centers for Medicare and Medicaid Services (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 payments that tie payment to cost and quality (APMs). 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 refreshed the APM Framework in 2017 to reflect changes to the health care marketplace—i.e., to capture the introduction of a new payment model and delivery system integration. The four categories in the Framework stayed the same with only slight modifications to the payment models and subcategories. Spending through payment models 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) 2017 or most recent 12 months.

Numerator: The numerators will generally track to the subcategories and payment models listed in the refreshed APM Framework. Health plans will report the total estimated payment amounts of categories 1 through 4 payments made to providers in CY 2017 or most recent 12 months.

Targeted Respondents

In order for this effort to yield a meaningful representation of the public and private insurance markets, we are targeting major health plans that, together, represent greater than 60% of covered lives across the commercial, Medicare Advantage, Medicaid, and Fee-for-Service Medicare 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 2017 APM Measurement Effort which represented 84% of covered lives in four market segments (a substantial increase from 64% of covered lives in 2016), we believe that a sufficient number of health plans will participate in the 2018 APM Measurement Effort so that the resulting data will give a strong indication of the national direction.

2018 National APM Metric Overview

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, we are targeting state-based insurers. 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). For example, this year the LAN and AHIP plans to field a joint survey through a Qualtrics tool to collect payment data from participating plans.

APM Data Collection & Reporting

For data collection, we will provide participating health plans, Fee-for-Service Medicaid states and Fee-for-Service Medicare with access to an online data collection survey through Qualtrics for each of the lines of business in which they are involved—commercial, Medicaid, and/or Medicare Advantage. Health plans will respond to one or more surveys, depending on their lines of business. Fee-for-Service Medicaid states and Fee-for-Service Medicare will respond to one survey. The surveys will contain specific instructions for each metric, including 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. After the payers submit these data, the LAN will cross check responses to identify whether any data that appears to be outliers and requires correction. The LAN 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 [#] of health plans, [#] of Fee-for-Service Medicaid states and Fee-for-Service Medicare participated in the data collection, which represents [#] of covered lives and approximately [%] of the total covered population within a given calendar year. In addition, this year the LAN plans to report the covered lives and percent of the population covered in each market segment: the survey captured approximately [#] commercial covered lives, which is [%]; [#] Medicaid covered lives, which is [%]; [#] Medicare Advantage covered lives, which is [%]; and [#] Fee-for-Service Medicare covered lives, which is [%].

Among this proportion, [%] of commercial health care payments are in category 1, [%] in category 2, [%] in category 3 and [%] in category 4; [%] of Medicaid health care payments are in category 1, [%] in category 2, [%] in category 3 and [%] in category 4; [%] of Medicare Advantage health care payments are in category 1, [%] in category 2, [%] in category 3 and [%] in category 4; and [%] of Fee-for-Service Medicare health care payments are in category 1, [%] in category 2, [%] in category 3 and [%] in category 4. In addition, the LAN plans to report subcategory percentages by each line of business if there are a sufficient number of responses in each subcategory.

2018 National APM Metric Overview

Note that the LAN collected APM information by line of business last year but did not report those results, because AHIP and BCBSA did not report their aggregated data by line of business. This meant the LAN could not produce an aggregated result. This year both BCBSA and AHIP will voluntarily collect the same payment model data the LAN is collecting, to include capturing it by line of business, with AHIP and the LAN fielding a joint survey through Qualtrics. While AHIP will collect some information that the LAN will not receive, the LAN will receive APM data from AHIP member plans and non-AHIP payers, and we have thus increased our burden estimate to reflect an increased number of plans reporting directly to the LAN. In contrast, BCBSA will field its own survey for its own purposes in alignment with the LAN's APM methodology, though the LAN will only receive aggregated data with no access to individual BCBSA member plan responses.

Finally, the LAN, AHIP, and BCBSA will also ask five simple informational questions about the current and future state of payment reform. These questions are straightforward opinion based questions from the payer's perspective. See informational questions attachment for more information and APM data collection survey tool to review each of the five questions.