2021 National APM Metric Overview

This information request involves collecting information from commercial, Medicaid, and Medicare Advantage health plans as well as Traditional Medicare and state Medicaid agencies 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, including the adoption of two-sided risk arrangements that meet parameters similar to those outlined in the CMS Quality Payment Program (QPP) for determining Advanced Alternative Payment Models (AAPMs). 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 payers 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) 2020 or most recent 12 months for which they have data available.

Numerator: The numerators will generally track to the subcategories and payment models listed in the refreshed APM Framework. Payers will report the total estimated payment amounts of categories 1 through 4 payments, by subcategory, made to providers in CY 2020 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 the U.S. covered population. 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. Additionally, the LAN is working with states and Medicaid associations to recruit state Medicaid agencies who pay health care providers directly.

The LAN strives to broaden its reach by increasing the number of payers participating in the LAN who are committed to: 1) implementing APMs and 2) submitting data that, when aggregated with others', will categorize how payers are paying providers on a national scale. Given payer involvement in the LAN events to date (estimated at over 250 organizations), and the strong participation in the LAN's 2019 APM Measurement Effort, which represented 77% of

covered lives in four market segments (the same as the 77% of covered lives represented in the 2018 Effort), we believe that a sufficient number of health plans will participate in the 2021 APM Measurement Effort so that the resulting data will give a strong indication of the national direction.[1]

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 payers as are necessary to reach that threshold. In effect, this will require recruiting payers across a variety of regions and states, yielding a cohort of health plans and state Medicaid agencies that cover much of the U.S. market. For instance, in addition to the very large national insurance companies, we are targeting state-based insurers. We are also 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), Alliance of Community Health Plans (ACHP), and National Association of Medicaid Directors (NAMD). For example, the LAN and AHIP fielded a joint survey in 2018 through a Qualtrics tool to collect payment data from participating plans and continue to collaborate annually on the Qualtrics tool to ensure greater consistency in data collection.

APM Data Collection & Reporting

For data collection, we will provide participating health plans and state Medicaid agencies access to an online data collection survey through Qualtrics. The survey includes questions for each of the lines of business—commercial, Medicaid, and/or Medicare Advantage. Health plans will submit data for multiple lines of business, depending on the markets they serve. State Medicaid agencies who pay providers directly and Traditional Medicare will report dollars for a single line of business. 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 appear to be outliers and require 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 Refreshed Framework.

At the end of the data collection period and after aggregation and analysis, the LAN plans to report the number [#] of health plans, number [#] of state Medicaid agencies, and to report that Traditional Medicare participated in the data collection. The LAN also plans to report the number [#] of covered lives represented and approximately the percentage [%] of the total covered population within a given calendar year. In addition, the LAN plans to report the covered lives and percent of the population covered in each market segment (i.e., the number [#] of commercial covered lives captured in the survey, and percentage [%] of overall commercial

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[1] Due to the pandemic, the LAN conducted a "flexible measurement effort" in 2020, extending the submission period to allow plans to submit two years of data in 2021. Results from 2020 (based on CY 2019 data) will be reported concurrently with 2021 results (based on CY 2020) in late 2021. Approximately 90% of health plans who submitted data to the LAN in 2019 continued to submit data in 2020 under the flexible measurement timeline.

lives; number [#] of Medicaid covered lives, and percentage [%] of overall Medicaid lives; number [#] of Medicare Advantage covered lives, and percentage [%] of overall Medicare Advantage lives; and number [#] of Traditional Medicare covered lives, and the percentage [%] of overall Traditional Medicare lives).

Additionally, the LAN plans to report, among this proportion, percentage [%] of commercial health care payments in category 1, percentage [%] in category 2, percentage [%] in category 3 and percentage [%] in category 4; percentage [%] of Medicaid health care payments in category 1, [%] in category 2, percentage [%] in category 3 and percentage [%] in category 4; percentage [%] of Medicare Advantage health care payments are in category 1, percentage [%] in category 2, percentage [%] in category 3 and percentage [%] in category 4; and percentage [%] of Traditional Medicare health care payments are in category 1, percentage [%] in category 2, percentage [%] in category 3 and percentage [%] in category 4. Following the successful experience of the 2019 Effort, the LAN plans to report subcategory percentages by each line of business if there are a sufficient number of responses in each subcategory.

Once again, and the same as 2020, both BCBSA and AHIP will voluntarily collect the same payment model data the LAN is collecting at the same level of granularity through their own surveys in alignment with the LAN's APM methodology. The LAN plans to recruit 50 health plans in 2021 to submit data directly to the LAN. The LAN will receive aggregated data from AHIP and BCBSA, with no access to individual member plan responses.

Finally, the LAN, AHIP, and BCBSA will also ask nine, simple informational questions about the current and future state of payment reform. Five of these questions were also asked in the 2018, 2019, and 2020 efforts. The LAN added four new informational questions to better understand primary care payment models and incentives within APMs to address health equity. These questions are straightforward opinion-based questions from the payer's perspective. For more information, see the APM data collection survey tool to review each of the questions.