2022 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. The LAN adapted the Centers for Medicare and Medicaid Services (CMS) 2015 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) 2021 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 2021 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 2020 and 2021 APM Measurement Effort, which represented 72.5% and 80.2% of covered lives, respectively across four market segments, we believe that a similar number of health plans will participate in the 2022 APM Measurement Effort so that the resulting data will give a strong indication of the national direction.

2022 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 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 large national insurance companies, we continue to target state-based insurers. We are also working in conjunction with major health plan associations including 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 have fielded a joint survey since 2018 using Qualtrics, an online data collection tool, to gather payment data from participating plans and continue to collaborate annually on the Qualtrics tool to ensure 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 survey 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 and Traditional Medicare, will quantify the dollars flowing through the categories and subcategories specified in the Refreshed Framework. Note, the LAN plans to ask its direct participants if they are interested in opting in to be publicly recognized for participation in the 2022 Measurement Effort. This will allow the LAN to publicly acknowledge the participation of individual health plans while also protecting their individual data.

At the end of the data collection period and after aggregation and analysis, the LAN plans to report the total number [#] of health plans (commercial and Medicaid MCOs), the total number [#] of state Medicaid agencies, and Traditional Medicare participated in the data collection effort. 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 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 2020 and 2021 Effort, the LAN plans to report subcategory percentages by each line of business if there are enough responses in each subcategory.

Once again, and the same as 2020 and 2021, 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 approximately 50 health plans in 2022 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 eight informational questions about the current and future state of payment reform, and the role health equity plays in payment initiatives. Five of these questions were asked in the 2018, 2019, 2020, and 2021 efforts. The LAN will continue to ask informational questions that were introduced in 2021 to understand the impact of COVID-19 on APMs, namely health equity. These questions are straightforward, opinion-based questions from the payer's perspective. For more information, see informational questions attachment and APM data collection survey tool to review each of the questions.