Commercial health plans, Managed Care Organizations (MCOs), state Medicaid agencies, Medicare Advantage (MA) plans, and Medicare voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

In 2020, 40.9% of U.S. health care payments, representing approximately 238.8 million Americans and 80.2% of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:

- **Commercial**: 35.5%
- **Medicare Advantage**: 58%
- **Traditional Medicare**: 42.8%
- **Medicaid**: 35.4%

*Combination of Categories 3B, 4A, 4B, & 4C Represents Two-Sided Risk APMs

**TRENDS OVER TIME**

Since its inception in 2015, the LAN has measured the amount of U.S. health care payments that flow through alternative payment models (APMs). Over time, the LAN refined its measurement process to examine APM adoption by line of business (LOB) and payments by subcategory within the four categories of the LAN's Refreshed APM Framework.

The line graph shows how APM spending in Categories 3 and 4 changed year-over-year by LOB. The bar graph illustrates the adoption of two-sided risk APMs (Categories 3B, 4A, 4B, 4C) by line of business since 2018.

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**Categories 3-4 Spend By Line of Business: Data Years 2015-2020**

- **2015**: 20%
- **2016**: 25%
- **2017**: 30%
- **2018**: 35%
- **2019**: 40%
- **2020**: 45%

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**Categories 3B-4 By Year and Line of Business: Data Years 2018-2020**

- **Category 4 (Lighter Color)**
- **Category 3B (Darker Color)**

- **All Lines of Business**
- **Commercial**
- **MA**
- **Medicaid**
- **Medicare FFS**

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Commercial, Medicare Advantage (MA), Medicaid, and Medicare FFS data are captured in the All Lines of Business (LOB) line. The LAN started to capture spend by LOB in 2018 looking back at 2017 data.
### AGGREGATED DATA

- **39.3%**
  - **CATEGORY 1:** Fee-for-Service - No Link to Quality & Value
    - A: Foundational Payments for Infrastructure & Operations
    - B: Pay-for-Reporting
    - C: Pay-for-Performance
  - **19.8%**
    - **CATEGORY 2:** Fee-for-Service - Link to Quality & Value
      - B: Condition-Specific Population-Based Payment
      - C: Comprehensive Population-Based Payment
      - A: Integrated Finance & Delivery Systems
  - **6.7%**
    - **CATEGORY 3:** APMS Built on Fee-for-Service Architecture
      - B: Upside Rewards for Appropriate Care
      - C: Upside & Downside for Appropriate Care
    - **4.1%**
      - **CATEGORY 4:** Population-Based Payment
        - B: Condition-Specific Population-Based Payment
        - C: Comprehensive Population-Based Payment
        - A: Integrated Finance & Delivery Systems

Based on 73 plans, 5 states, Traditional Medicare

### COMMERCIAL

- **51.5%**
  - **CATEGORY 1:** Fee-for-Service - No Link to Quality & Value
    - C: Pay-for-Performance
  - **32.1%**
    - **CATEGORY 2:** Fee-for-Service - Link to Quality & Value
      - C: Pay-for-Reporting
      - B: Comprehensive Population-Based Payment
      - A: Condition-Specific Population-Based Payment
  - **13%**
    - **CATEGORY 3:** APMS Built on Fee-for-Service Architecture
      - C: Upside Rewards for Appropriate Care
      - B: Upside & Downside for Appropriate Care
    - **3.4%**
      - **CATEGORY 4:** Population-Based Payment
        - C: Integrated Finance & Delivery Systems
        - B: Condition-Specific Population-Based Payment
        - A: Comprehensive Population-Based Payment

Representativeness of covered lives: Commercial - 62%

### MEDICARE ADVANTAGE

- **38%**
  - **CATEGORY 1:** Fee-for-Service - No Link to Quality & Value
    - C: Pay-for-Performance
  - **36.2%**
    - **CATEGORY 2:** Fee-for-Service - Link to Quality & Value
      - C: Pay-for-Reporting
      - B: Comprehensive Population-Based Payment
      - A: Condition-Specific Population-Based Payment
  - **21.8%**
    - **CATEGORY 3:** APMS Built on Fee-for-Service Architecture
      - C: Upside Rewards for Appropriate Care
      - B: Upside & Downside for Appropriate Care
    - **4%**
      - **CATEGORY 4:** Population-Based Payment
        - C: Integrated Finance & Delivery Systems
        - B: Condition-Specific Population-Based Payment
        - A: Comprehensive Population-Based Payment

Representativeness of covered lives: Medicare Advantage - 67%

### TRADITIONAL MEDICARE

- **15%**
  - **CATEGORY 1:** Fee-for-Service - No Link to Quality & Value
    - C: Pay-for-Performance
  - **37.8%**
    - **CATEGORY 2:** Fee-for-Service - Link to Quality & Value
      - C: Pay-for-Reporting
      - B: Comprehensive Population-Based Payment
      - A: Condition-Specific Population-Based Payment
  - **5%**
    - **CATEGORY 3:** APMS Built on Fee-for-Service Architecture
      - C: Upside Rewards for Appropriate Care
      - B: Upside & Downside for Appropriate Care
    - **3.5%**
      - **CATEGORY 4:** Population-Based Payment
        - C: Integrated Finance & Delivery Systems
        - B: Condition-Specific Population-Based Payment
        - A: Comprehensive Population-Based Payment

Representativeness of covered lives: Traditional Medicare - 100%

### MEDICAID

- **59%**
  - **CATEGORY 1:** Fee-for-Service - No Link to Quality & Value
    - C: Pay-for-Performance
  - **29.1%**
    - **CATEGORY 2:** Fee-for-Service - Link to Quality & Value
      - C: Pay-for-Reporting
      - B: Comprehensive Population-Based Payment
      - A: Condition-Specific Population-Based Payment
  - **6.4%**
    - **CATEGORY 3:** APMS Built on Fee-for-Service Architecture
      - C: Upside Rewards for Appropriate Care
      - B: Upside & Downside for Appropriate Care
    - **2.3%**
      - **CATEGORY 4:** Population-Based Payment
        - C: Integrated Finance & Delivery Systems
        - B: Condition-Specific Population-Based Payment
        - A: Comprehensive Population-Based Payment

Representativeness of covered lives: Medicaid (MCOs and state Medicaid Agencies) - 64%

### Combination of Categories 3B, 4A, 4B, & 4C
- Represents Two-Sided Risk APMs
- Percentage description here.

### Representativeness of covered lives:
- **Traditional Medicare - 100%**
- **Medicaid (MCOs and state Medicaid Agencies) - 64%**
- **Medicare Advantage - 67%**
- **Commercial - 62%**
- **Traditional Medicare - 100%**

### Combination of Categories 3B and all of Category 4
- Represents Two-Sided Risk APMs
**PAYERS’ PERSPECTIVE**

*What Do Payers Think about the Future of APM Adoption?*

87% think APM activity will increase

12% think APM activity will stay the same

0% think APM activity will decrease

1% not sure or didn’t answer

**Categories Payers Feel Will Increase the Most**

<table>
<thead>
<tr>
<th>Category</th>
<th>3B</th>
<th>3A</th>
</tr>
</thead>
<tbody>
<tr>
<td>...better quality of care?</td>
<td>Strongly Agree/Agree</td>
<td>92%</td>
</tr>
<tr>
<td>...more affordable care?</td>
<td>Strongly Disagree/Disagree</td>
<td>85%</td>
</tr>
<tr>
<td>...improved care coordination?</td>
<td>Strongly Disagree/Disagree</td>
<td>93%</td>
</tr>
<tr>
<td>...more consolidation among health care providers?</td>
<td>Strongly Agree/Agree</td>
<td>44%</td>
</tr>
<tr>
<td>...higher unit prices for discrete services?</td>
<td>Strongly Disagree/Disagree</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Top 3 Barriers:**
1. Provider willingness to take on financial risk
2. Provider ability to operationalize
3. Provider interest/readiness

**Top 3 Facilitators:**
1. Health plan interest/readiness
2. Provider interest/readiness
3. Government influence

**Does your Plan have a strategy to contract with providers using population-based APMs (i.e., HCP-LAN Category 4) over the next year?**

- 11% The strategy is/will mostly target small, independent primary care clinicians/practices.
- 15% The strategy is/will mostly target independent larger physician group practices.
- 61% The strategy is/will target a mix of provider types.
- 22% No, my Plan does not have a strategy to contract with providers using population-based APMs.
- 5% Other (text)

**SUMMARY STATISTIC STATEMENTS FOR INFORMATIONAL QUESTIONS**

(2018-2021 Measurement Effort Years, 2017-2020 Data Years)

**Over the past 4 years:**

- 87%-91% of health plan responses indicated that they think APMs will increase over the next 24 months
  - In no year did health plans say they thought APMs would decrease

- 45%-51% of health plan responses believed APM subcategory 3B would increase the most

**Health plans said the top three barriers to APM adoption are:**
- a. Provider willingness to take on financial risk
- b. Provider ability to operationalize
- c. Provider interest/readiness

**Health plans said the top three facilitators to APM adoption are:**
- a. Health plan interest/readiness
- b. Provider interest/readiness
- c. Government influence*

*In one of four years, government influence ranked #2.
If incentives are included in your value-based provider arrangements to improve health disparities, what specific Social Determinants of Health (SDoH) or delivery strategies are targeted for improvement or enhancement?

- Referrals to community-based organizations to address socioeconomic barriers
- Care coordination for services that address socioeconomic barriers
- Screening for socioeconomic barriers to health
- Food insecurity (e.g., offering resources for access to nutritious food)
- Data that tracks whether services were received (e.g., closed loop referrals)
- Safe transportation (e.g., incentives or partnerships in ride sharing programs)
- Housing insecurity (e.g., provider sponsored housing after a hospital discharge)
- Economic insecurity (e.g., connections to job placement or training services)
- Social isolation and loneliness (e.g., peer connection programs, group meetings, etc.)
- Other basic needs (e.g., providing clothing, diapers, or gift cards; helping with utilities or childcare; providing digital devices such as phones to access telehealth and thrive in new digital world, etc.)
- Multidisciplinary team models (e.g., social worker, community health worker, medical staff, doulas, etc.)
- Other

Is your Plan leveraging value-based provider arrangements to incent the reduction of health disparities?

- Collect standardized sociodemographic data
- Improve the quality and completeness of sociodemographic data
- Measure health disparities by stratifying along sociodemographic factors
- Improve patient consumer experience for targeted populations
- Improve performance on measures stratified by sociodemographic data
- No, my organization is not currently leveraging value-based provider arrangements to incentivize the reduction of health disparities