

APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS



LAN Insights into APM Adoption



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LAN Insights into APM Adoption

At its inception in 2015, the Healthcare Payment Learning and Action Network (LAN)¹ has adopted the goal of transitioning 30% of U.S. healthcare payments to alternative payment models (APMs) by 2016 and 50% by 2018. The LAN believes that moving to value-based payment is necessary to improve the quality, efficiency, and overall value of the American healthcare system. In October 2018, the LAN released the annual results of its [APM Measurement Effort](#), which demonstrates that [almost 34% of healthcare payments in 2017 were made through alternative payment models](#) – that is, shared-savings, shared-risk, bundled payments, or population-based payments. Given the growing interest in alternative payment models with downside risk, such as shared risk, bundled payments, and population-based payments, the LAN refined its measurement survey to capture greater detail of these models. The survey data found that 12.5% of all health care spending surveyed was in downside risk models in 2017. The measurement results also found that 90% of responding payers expect APM activity to increase and nearly half (48%) of payers identified subcategory 3B¹ as the APM subcategory to be most impacted. Furthermore, the enhanced survey examines how four different lines of business – commercial, Medicaid, Medicare Advantage, and Medicare FFS – are making progress toward the LAN goals, and reports findings at the payment or subcategory level within the four categories of the LAN’s [Refreshed APM Framework](#). The following insights explore APM progress at the aggregate level, line of business, and lessons learned from three years of measurement.

Aggregated Results

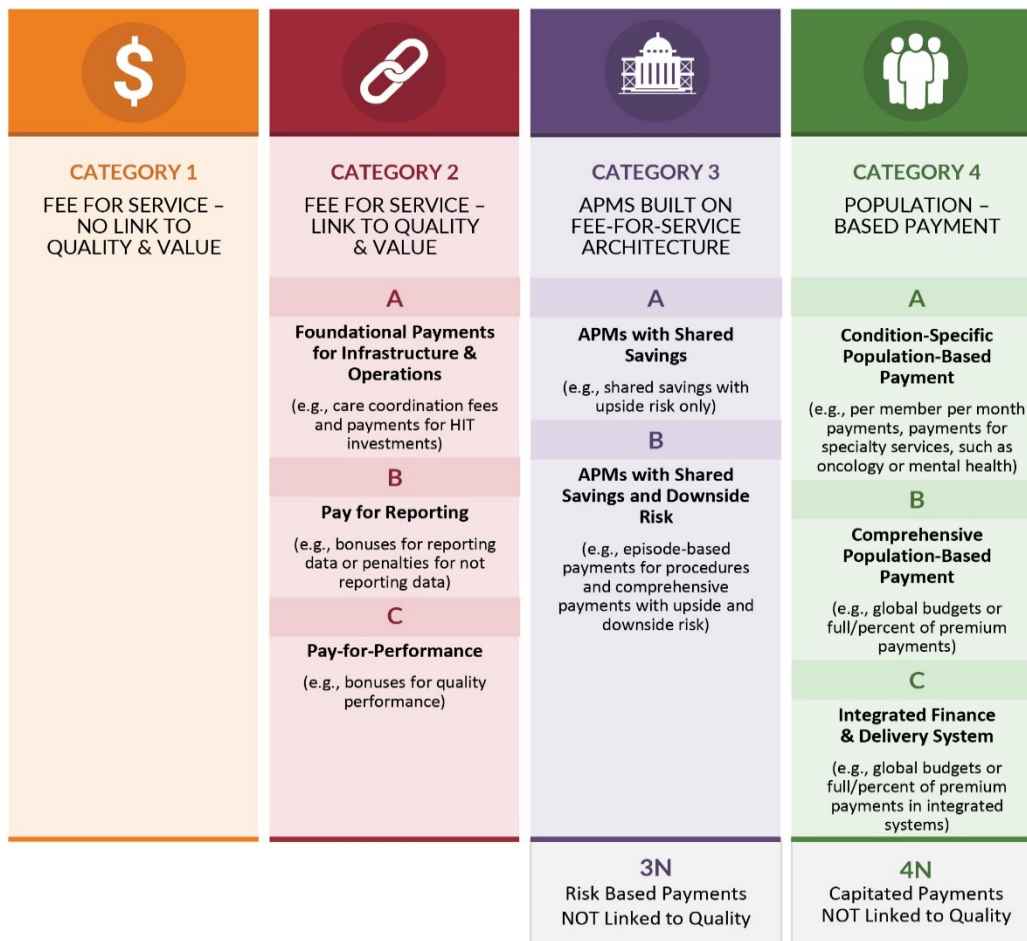
The LAN’s annual APM Measurement Effort has captured payments made in calendar years (CY) 2015, 2016, and 2017. To accomplish this, the LAN invited health plans and states from across the nation to report payments made to providers according to the Refreshed LAN APM Framework. At a high level, the categories and payment methods in the categories include, but are not limited to:

- Category 1: Traditional fee-for-service or other legacy payments not linked to quality
- Category 2: Foundational payments like care coordination fees or pay-for-performance
- Category 3: Shared-savings, shared-risk, bundled payments
- Category 4: Population-based payments and integrated finance and delivery systems

Figure 1 below depicts the categories and subcategories described in the Refreshed LAN APM Framework

¹ Category 3B: Fee-for-service-based shared-risk, Procedure based bundled/episode payments, and Population-based payments that are NOT condition specific.

Figure 1: LAN APM Refreshed Framework²



The LAN collaborated with [America’s Health Insurance Plans \(AHIP\)](#) and [Blue Cross Blue Shield Association \(BCBSA\)](#) to gather representative data on the types of payments health plans with commercial, Medicaid, and Medicare Advantage business made to healthcare providers in 2017. The LAN also collaborated with the [Center for Medicare and Medicaid Services \(CMS\)](#) to collect this data from Medicare FFS. In addition, the [Association for Community Affiliated Plans \(ACAP\)](#), the [Alliance of Community Health Plans](#), and the [National Association of Medicaid Directors](#) encouraged their member plans or managed FFS Medicaid states³ to participate in the LAN effort. For more information regarding the methods used and processes followed for the 2018 measurement effort, please see the [2018 APM Methodology and Results Report](#).

² Category 4 payments are not necessarily appropriate for all providers and markets. The LAN does not expect or intend that all payments will ever be in Category 4.

³ The term “Managed FFS Medicaid states” refers to states that pay providers directly, rather than operate through Medicaid Managed Care Organizations. Such states typically invest in payment models geared toward improving care quality and delivery for Medicaid beneficiaries.

Interpreting the Aggregated Results

In comparing the results of this year’s survey to the prior two years (Figure 2), adoption of Category 3 and 4 APMs increased 5 percentage points (or a 17% increase), bringing total APM spending to approximately \$385.5 billion nationally. While payment models in Categories 3 and 4 are the LAN’s primary focus, it is also important to note the changes in Categories 1 and 2. Since the first year of APM measurement by the LAN, payments made through Category 1 (payments with no link to quality) have decreased by 34%. Category 2 payments also decreased between last year’s and this year’s measurement, from 28% to 25%. While it is not possible from the LAN’s data collection process to track where these payments go year-to-year, payments in Categories 3 and 4 collectively have increased at a steady pace from 23% in the first year of measurement to 34% in this year’s effort. It is unlikely that payments in Category 1 with no link to quality moved directly to Categories 3 or 4; rather, Category 1 payments likely moved to Category 2, and payments previously made in Category 2 are now being captured in Categories 3 and 4.

**Figure 2: LAN APM Measurement Effort Results:
Comparison between 2015, 2016, and 2017 Payments**

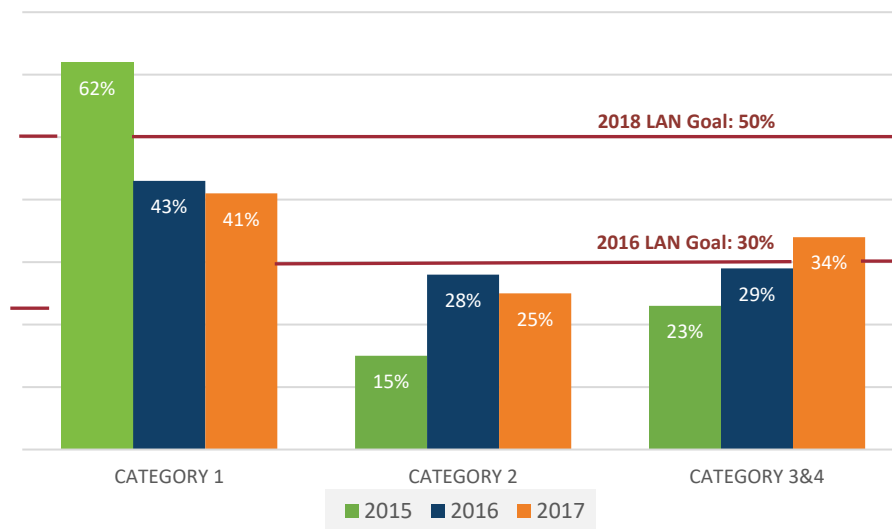


Figure 2 compares data from CY 2015, CY 2016, and CY 2017. In 2015, data was collected from 70 plans and 2 managed FFS Medicaid states, which represented 198.9 million lives or 67% of the U.S. covered population. In 2016, the data was collected from 78 plans, 3 managed FFS Medicaid states, and Medicare FFS. This represented 245.4 million lives or 84% of the U.S. covered population. In 2017, the data was collected from 61 plans, 3 states, and Medicare FFS, representing 226.3 million lives or 77% of the U.S. covered population.⁴

⁴ Berchick, E. R., Hood, E., and Barnett, J.C., Current Population Reports, P60-264, Health Insurance Coverage in the United States: 2017, U.S. Government Printing Office, Washington, DC, 2018.

Changes in Category 1:

The decrease in payments in Category 1 appears to be driven by Medicare FFS and by health plans consistently reporting that they continue to negotiate contracts that compensate providers using some type of quality measurement. Tying some payment to quality is a move away from paying purely on fee-for-service without any link to quality. Additionally, based on the responses to the informational questions, 90% of health plans believe that APM adoption will increase in the next 24 months, signaling a commitment to move away from Category 1. When Medicare FFS dollars are removed from Category 1, we see that Category 1 payments rise to 57%.

Changes in Category 2 – 4:

Despite over 50% of Medicare FFS payments in Category 2, Category 2 payments decreased modestly from the last measurement effort to 25%. If we remove Medicare FFS's dollars from Category 2, payments in this category drop sharply to 12%, roughly in half. This is not to say that the other market segments are using pay-for-performance less as a contracting strategy; rather, two dynamics are likely in play. First, pay-for-performance is generally the first step for providers before they move to contracts that involve more complex gainsharing, like shared-savings, captured in 3A. Subcategory 3A⁵ has a significant proportion of APM activity (19.4%, the majority of which is the shared-savings payment model), so it is possible that the “training wheels” of historic pay-for-performance contracts are being replaced with shared-savings contracts. Second, more providers are taking on shared-savings arrangements as part of the accountable care organization (ACO) movement, and pay-for-performance dollars might be added to these contracts. There were 480 ACOs participating in Medicare Shared Savings Program (MSSP) in 2017, with 9 million assigned beneficiaries. Of these ACOs, 82%, or 460, were in Track 1 (Non-Risk Based).⁶ Meanwhile, there were approximately 700 commercial ACO contracts in 2017, and slightly more than 90 ACO contracts in the Medicaid sector.⁷ Anecdotally, it is known that some shared-savings arrangements have a pay-for-performance bonus “layered” on top.

It is difficult to determine whether Category 3 or Category 4 is driving the overall increase in these categories because previous years' results reported aggregated total dollars in Categories 3 and 4 combined; however, this year, we examined Category 3 and Category 4 separately. Based on 2017 data, aggregated results indicate that subcategory 3A has the most APM dollars of these two categories, at 21.1%, while 3B has the second-most APM dollars flowing through it at 8.7%. Subcategories 4A, 4B, and 4C combined had 3.8. Given the preponderance of Category 3 payments in 2017, it is reasonable to conclude that the growth in Category 3 is driving the increase in the combined Categories 3 and 4.

⁵ 3A and 3B percentages represent data from 61 health plans, 3 states, and FFS Medicare.

⁶ CMS.gov Medicare Shared-savings Program Fast Facts, January 2018, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf>

⁷ Muhlestein, D., Saunders R., Richards, R., McClellan, M., “Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018. Health Affairs. August 14, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20180810.481968/full/>

In a similar vein, the aggregated results at the subcategory level indicate that upside risk APMs in subcategory 3A at 21.1% are the most dominant APM type by almost 9 percentage points – a significant margin – given that subcategory 3B and all of Category 4 combined equal 12.5%.

In 2017, 1% of MSSP ACOs (six total) were in Track 2 (two-sided risk), 8% (36) were in Track 3 (two-sided risk), and 9% (45) were in the ACO Investment Model (AIM), a CMMI Initiative, which is a subset of MSSP ACOs.⁸ Over time, the expectation is that payments in 3A will convert to 3B, indicating ACO contracts maturing from shared-savings in the early years to shared-risk in the later years of the contract. This transition might occur earlier as conditions for participating in MSSP change. CMS has issued a [proposed rule](#) that encourages all ACOs in the program to participate in into shared-risk arrangements (categorized as 3B).

As noted previously, Medicare FFS has had a significant impact on the reduction in Category 1 and the increase (or relative stability) of Category 2. The impact Medicare FFS has on combined APM Categories 3 and 4, however, is less dramatic. The combined Categories 3 and 4 is 34% with Medicare FFS, while without Medicare FFS, the combined Categories 3 and 4 is 31%.

Line of Business Results

New to the 2018 Measurement Effort is the examination of APM activity by the four lines of business (LOB) - commercial, Medicaid, Medicare Advantage (MA), and Medicare FFS - using the lookback methodology. While there are methodological and sampling differences that do not allow for a direct comparison, the LAN does have a frame of reference for LOB information – the 2016 Point-in-Time data.

Line of Business Comparison: 2016 Point-in-Time

The LAN previously reported line of business APM adoption in 2016 using a point-in-time methodology that captured data from 40 health plans and two states. These data showed that Medicare Advantage had the most payments in Categories 3 and 4 (41%), followed by commercial (22%), and then Medicaid (18%).⁹ Medicare FFS reported its 2016 point-in-time metrics data at 31%.¹⁰

Line of Business Comparison: 2017 Lookback

All lines of business fall in the same order in terms of APM adoption in the 2017 lookback data reported by the 2018 Measurement Effort as they did in the point-in-time data: Medicare Advantage still has the most in Categories 3 and 4 (49.5%), Medicare FFS has 38.3%, the commercial market has 28.3%, and Medicaid is at 25%. Figure 4 compares 2016 point-in-time data to 2017 lookback data.

⁸ United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2017). Fast Facts: All Medicare Shared-savings Program Accountable Care Organizations. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>

⁹ Healthcare Payment Learning & Action Network “Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicaid, Medicare Advantage, and Fee-for-Service Medicare Programs.” October 25, 2016 <https://hcp-lan.org/workproducts/apm-measurement-final.pdf>

¹⁰ United States Department of Health and Human Services, Press Office. “HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule.” March 3, 2016. <https://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>

Table 1: 2016 Point in Time Data Compared to 2017 Lookback Data
(in order of highest APM Categories 3 & 4 to lowest)

	2016 Point-in-Time Categories 3&4 Combined ¹¹	2017 Lookback Categories 3&4 Combined
Medicare Advantage	41%	49.5%
Medicare FFS	31%	38.3%
Commercial	22%	28.3%
Medicaid	18%	25%

Figure 4: Line of Business/Category Comparison

Category Comparison by Line of Business

Figure 5 shows each line of business and how much spending is in each category. Medicaid has the most in Category 1 (67.8%), Medicare FFS has the most in Category 2 (51.2%), and Medicare Advantage has the most in APM Categories 3 and 4 (39.2% and 10.3%).

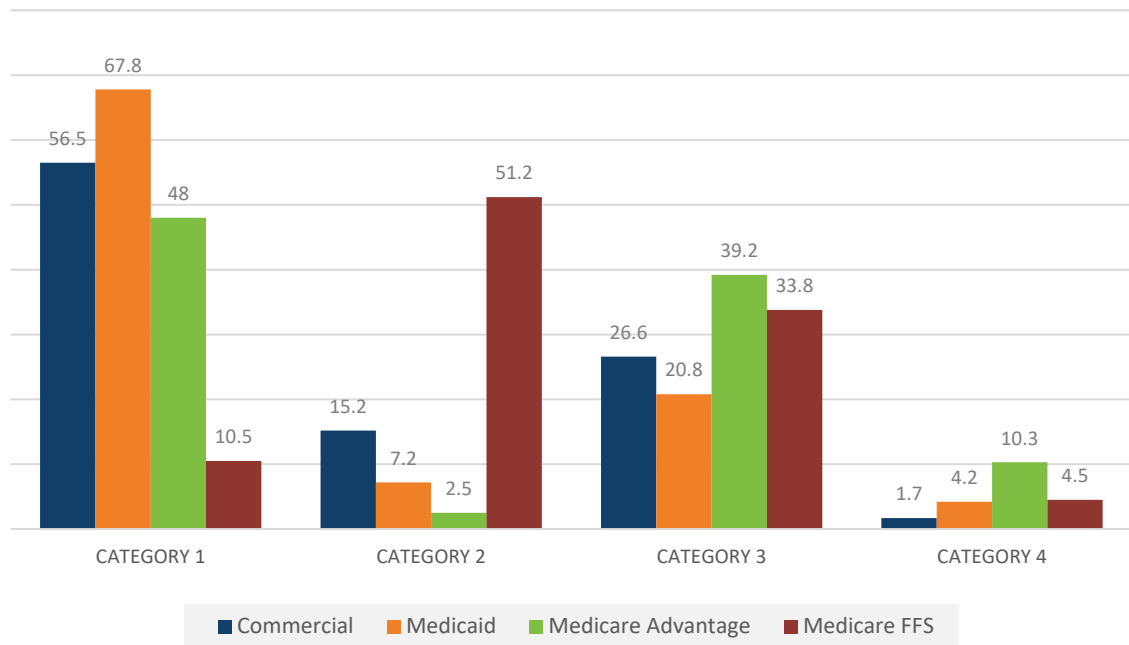


Figure 4 shows each APM category by line of business. Note: total covered lives¹² and total healthcare spending in each line of business varies.

The following section examines each market segment’s individual data and identifies notable comparisons to other lines of business and comparisons to the aggregate data without Medicare FFS.

¹¹ 2016 Point-in-Time data in the Medicare Advantage, commercial, and Medicaid lines of business is based on data from 40 health plans and 2 states, which is a smaller dataset than the 2017 Lookback dataset (61 health plans, 3 states).

¹² See Methodology and Results Report for details.

Commercial

The commercial market has over half (56.5%) of its dollars flowing through Category 1, fee-for-service payments with no link to quality. This is almost 38% higher than this year's aggregate result (41%). The commercial market, however, has fewer dollars in Category 2 (15.2%), which is 39% lower than the aggregate (25%). As stated previously, Medicare FFS has a significant impact on the aggregate data in Categories 1 and 2. If we examine the commercial market data without Medicare FFS data, the story looks different. Without Medicare FFS, the aggregated dollars in Category 1 is 56.7% and 12.1% in Category 2. Both aggregate figures without Medicare FFS are more closely aligned with the commercial market data.

In exploring Categories 3 and 4, the commercial market has 26.6% of dollars in Category 3 and 1.7% in Category 4, for a total of 28.3% in combined Categories 3 and 4, which is a noteworthy increase over the 2016 point-in-time commercial data from Table 1 (22%). However, the commercial market is lower in both categories relative to the aggregate (30% in Category 3 and 4% in Category 4), but the differential is not nearly as stark as the difference in Categories 1 and 2. Within Categories 3 and 4, the data show that the commercial market has the greatest proportion of spending in Category 3A – APMs with shared-savings (18.4%) and has the least amount in Category 4 (1.7%) A possible explanation for spending in 3A might be attributed to a concerted effort by commercial health plans to contract with accountable care organizations (ACOs). In 2016, approximately 28.3 million people were covered by an accountable care arrangement - 17.2 million of whom were covered under commercial contracts.¹³ Given the volume of commercial lives in ACO arrangements, it is reasonable to conclude that there is a corresponding significant level of payments and financial investment in payment models that support ACOs, such as shared-savings. Most contracts between health plans and ACOs start in shared-savings arrangements (3A) before moving to shared-risk arrangements (3B) or in Category 4. The data do not provide insights as to why the commercial market has the least amount of payments in Category 4 as compared to the other market segments.

To many who watch commercial market trends, it is not unusual for the commercial market's results to generally be between the Medicare Advantage market and the Medicaid market. Unlike the health plans in the Medicare Advantage and Medicaid line of business, the health plans in the commercial market are not financed publicly and uniformly but rather in a fragmented manner with an assorted array for payers including: self-funded employers, fully-insured employers, and even individual consumers through the exchange business. Given that researchers link high APM adoption in Medicare Advantage to its capitated financing model that rewards quality achievement, it is reasonable to conclude that the lack of capitated financing to commercial payers may explain the lower levels of APM adoption in the commercial market.

Additionally, the commercial market typically follows Medicare Advantage on certain payment innovations, such as shared-savings, once Medicare Advantage efforts are proven successful.

¹³ Muhlestein, D., and McClellan, M., "Accountable Care Organizations in 2016: Private and Public Sector Growth And Dispersion." Health Affairs. April 21, 2016. <https://www.healthaffairs.org/doi/10.1377/hblog20160421.054564/full/>

Medicaid

To the extent reported, health plans and states serving the Medicaid market have approximately 68% of payments in Category 1, which is the most of the four market segments. Current Medicaid payments made through legacy payments are above the aggregate view from the first measurement year, which was 62%.

When examining APM Categories 3 and 4, Medicaid shows the least activity of the four market segments at 25%, and is lower than the aggregated results of 32%. Medicaid Categories 3 and 4 results are also lower than the aggregate results from last year's result (29%). On the surface, however, the Medicaid data does not trail far behind the commercial results in Categories 3 and 4, which is 28.3%. Also notable is that Medicaid has more dollars in Category 4 (4.2%) than the commercial market (1.7%).

Challenges of designing an APM in Medicaid and assessing results include:

- Demonstration projects with shared-savings and other APM models expiring without renewal, a trend that researchers point to as shrinking the number of ACO contracts in Medicaid in 2017¹⁴
- Legislative and regulatory issues that state Medicaid agencies may have to navigate to implement certain APM models
- Rapid increase in the number of Medicaid-covered lives in states that have expanded eligibility potentially constraining internal resources
- Uncertainty at the federal level, given that attempts to repeal the Affordable Care Act may have deterred investments in this area
- High turnover rate and limited staffing resources within state Medicaid agencies¹⁵ may represent a barrier to adoption and a barrier to measurement

Perhaps for this final reason, the 2018 APM Measurement Effort achieved a lower level of representativeness in the Medicaid market than the other lines of business, potentially driven by payers and Managed FFS states pursuing Categories 3 and 4 models not having had the time or resources available to respond to the Measurement survey. It should also be noted that adults with dual eligibility for Medicaid and Medicare coverage were excluded from reporting for the Medicaid sector. Because these patients often represent a disproportionate level of spending,¹⁶ and to the extent that these beneficiaries are attributed to providers in APM contracts, spending on their behalf would not be captured in the Medicaid line of business data of this effort.

¹⁴ Muhlestein, D., Saunders R., Richards, R., McClellan, M., "Recent Progress In The Value Journey: Growth Of ACOs And Value-Based Payment Models In 2018." Health Affairs. August 14, 2018.

<https://www.healthaffairs.org/doi/10.1377/hblog20180810.481968/full/>

¹⁵ Matulis. R. and Lloyd, J., "The History, Evolution, and Future of Medicaid Accountable Care Organizations." Center for Healthcare Strategies, February 2018. https://www.chcs.org/media/ACO-Policy-Paper_022718.pdf

¹⁶ Bynum, J.P.W., Austin, A., Carmichael, D., and Meara. E., "High-Cost Dual-Eligibles' Service Use Demonstrates Need For Supportive And Palliative Models Of Care" Health Affairs. July 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5633373/>

Medicare Advantage

The Medicare Advantage market has just under half of its payment flowing through Category 1 (48%). Like the commercial and Medicaid markets, this is higher than the aggregate of 41%. If we look at the Medicare Advantage results in Category 1 against the aggregate without Medicare FFS's data, MA is less than the aggregate by 15% and also has less in Category 1 than the commercial and Medicaid markets.

Conversely, Medicare Advantage has the most dollars in APMs Categories 3 and 4 (39.2% and 10.3%, respectively). We can break down these categories further, which may provide further insights. Of the 39.2% in Category 3, 25.3% is attributed to subcategory 3A, which includes shared-savings, and 13.9% is attributed to subcategory 3B, which includes shared-risk. Medicare Advantage has 10.3% in Category 4, and 9% of this is in subcategory 4B, comprehensive population-based payments.

Researchers attribute the APM innovation in the Medicare Advantage market to its financing structure, in which plans are paid a monthly, capitated rate derived using each enrollee's age, location, and health status. If plans reduce costs while maintaining or improving quality, they can keep savings, receive bonuses, and increase their enrollment of beneficiaries. Given that plans are financed through a value-based arrangement with the federal government, it is logical that the plans themselves would apply this same approach to how they pay providers.¹⁷

Medicare FFS

One of the most interesting data points of this year's Measurement Effort comes from Medicare FFS. Medicare FFS has only 10.5% of its payments in legacy payments, or Category 1. Medicare FFS's payments in Category 1 are 74% less than this year's aggregate (41%) across all payers.

While Medicare FFS has the least amount of payments in Category 1, it has the most amount of payments in Category 2 (51%). This is significantly higher than any of the other market segments and higher than the aggregate from all three of the measurement efforts (15%, 28%, and 24% respectively).

These large Medicare FFS differences in Categories 1 and 2, in comparison to the rest of the market segments, are largely explained by CMS's long-standing effort to link Medicare FFS payments to healthcare quality through a range of nationwide value-based purchasing [programs](#). For example, the [Hospital Readmissions Reduction Program](#) lowers payments to Inpatient Prospective Payment System (IPPS) hospitals with too many readmissions and the [Value Modifier Program](#)¹⁸, which determines the amount of Medicare payments to physicians based on their performance on quality and cost measures contributed to Category 2 spending. The [Quality Payment Program](#) is a more recent example of CMS's commitment to link Medicare FFS to quality and encourage physicians to participate in APMs that have some level of risk.

¹⁷ Moffit, R., Numerof, R.E., and Buseman, C.M., "Let the Market Compete: Learning From Medicare Advantage To Move Toward Value-Based Care" Health Affairs. January 2018
<https://www.healthaffairs.org/doi/10.1377/hblog20180122.210298/full/>

¹⁸ The Value Modifier Program was in effect in 2017 and will sunset in 2018. The Quality Payment Program will incorporate aspects of the Value Modifier Program.

When examining Categories 3 and 4, Medicare FFS market’s results are not as stark. Medicare FFS has 34% in Category 3 and 4.5% in Category 4, or 38.5% combined. These figures align with results from the Medicare Advantage market segment and are higher than the commercial market segment.

Payers’ Perspectives on the Future of APM Adoption

For the first time, the LAN Measurement Effort added semi-qualitative informational questions¹⁹ to the Measurement survey in order to better understand the payers’ perspectives on APM adoption. The survey questions are structured such that the first set of questions explores where payers believe the healthcare system is headed, the second set explores how payers think APM adoption will impact the healthcare marketplace at a high-level, and the final section allows payers to identify the top facilitators and barriers to APM adoption. The intention of the informational questions is to provide insight and guidance to stakeholders on where to focus future initiatives that are intended to improve the value of healthcare.

When asked about the future of APM adoption, 90% of payers indicated that APM activity will increase, while zero payers surveyed indicated that APM activity will decrease. This result shows clear agreement amongst payers that the industry intends to continue development and implementation of APMs. In responding to a follow-up question regarding which APM subcategory will be most impacted, nearly half (48%) of payers identified subcategory 3B: Fee-for-service-based shared-risk, Procedure based bundled/episode payments, and Population-based payments that are NOT condition specific. Subcategory 3B is the only APM subcategory outside of Category 4 that places providers at risk for their performance. Its selection as the APM to be most impacted by future APM adoption reflects a likely shift to two-sided risk arrangements. Apart from the 48% that selected 3B as the APM most impacted, another 25% of payers identified subcategory 3A (Traditional shared-savings, Utilization-based shared-savings) as the APM most impacted by future activity. As previously discussed in this paper, it is likely that growth in 3A, which represents 21.1% of total dollars across all lines of business, drove the growth in Category 3 and 4 payments captured by the 2018 Measurement Effort. Future studies reporting at the subcategory level will allow for a more definitive trend comparison of the growth of each APM.

Payers responded that APM activity will result in better quality of care, more affordable care, and improved care coordination. While they felt that payment reform may drive further consolidation among healthcare providers, they did not expect higher unit prices as a consequence. Together, these impressions offer an optimistic view of the impact of APMs on healthcare value. It is important to note that these results reflect the payers’ perspectives, specifically that of the 70 health plans and 3 FFS Medicaid states who participated in the Measurement effort. The same questions could produce contrasting results when surveying different stakeholder groups. Given that APM activity has only recently proliferated across the United States (as recently as 2015, Category 1 made up 62% of payments), only time and rigorous evaluations can validate these payer expectations.

The payer-identified barriers and facilitators to APM adoption represent actionable steps for stakeholders who are interested in seeing further APM adoption. Respondents were asked to select up to three choices from a list of nine options, including the option of writing out their own answer; the barriers and the facilitators questions each employed the same list of answer options. Two of the

¹⁹ See Methodology and Results report for a complete list of questions and results.

options – “ability to operationalize” and “willingness to take on financial risk” – did not specify the stakeholder group involved in these choices as barriers and/or facilitators, leaving the LAN and readers to interpret the results within the larger context of the healthcare marketplace and the LAN Measurement Effort as a whole. Because insurers are already risk-bearing entities, one can infer that the “willingness to take on financial risk” refers to provider willingness. This interpretation is reinforced by the result that subcategory 3B, which is characterized by its incorporation of financial risk for providers, will be the most impacted by future APM activity. The identification of “ability to operationalize” as a top barrier also requires interpretation, as APM adoption represents approaches to provider payment that may push the operational limits of all stakeholders. In this case, it is more difficult to determine *whose* ability to operationalize is in question. For example, one participating payer responded “Access to electronic medical record (EMR) data and interoperability of systems” as a top barrier. Interoperability of systems can represent a challenge to providers, payers, and potentially other stakeholders, and may require significant multi-stakeholder collaboration and potentially regulatory guidance to chart a path forward.

Identifying top facilitators provides insights for potential future strategies. The fact that payers selected “payer interest/readiness” as the top facilitator to APM adoption speaks to the point that payers are broadly supportive of payment reform. The identification of “purchaser interest/readiness” as the second top facilitator showcases the vital role purchasers play in promoting the use of APMs. Finally, there was a tie in the number of payers who identified “provider interest/readiness” and “government influence” as top facilitators. Taken together, the identification of these top facilitators provides an encouraging outlook to the future of APM adoption, as it appears that the four major stakeholder groups - payers, purchasers, providers, and the government - all have potential to facilitate APM adoption.

Lessons Learned

The LAN’s goal is to accelerate the adoption of APMs to create a healthcare system that results in higher quality care that is both innovative and affordable. Tracking how quickly, or in what ways, the nation’s healthcare payments are changing is no easy task. While there is much more to uncover, over the last three years of measurement, the LAN discovered many things.

Value in Alignment

First, there is clear value in alignment. The LAN developed standard definitions, frequently asked questions, and methodological approaches to help health plans classify and report data. Myriad variations in health plan programs means, however, that classifying payments into single categories (when they almost never exist in isolation) is complex, and requires a high-touch, interactive approach to ensure the classifications are appropriate as data is collected. In addition, plans are frequently asked for similar data from different entities, so the more the LAN proactively discusses and standardizes definitions and data requests of health plans, the lower the burden for health plans to participate in measurement efforts. Working to align with partners such as AHIP, BCBSA, and others in advance of the measurement effort helped address these issues and minimize variation in interpretations and approaches.

Value in Benchmarking

Health plans of all sizes are interested to learn where they stand in the movement toward APMs and how they compare to the market. Some health plan APM strategies are dictated by market conditions, others by factors such as data system limitations or provider readiness. Having conducted many interactions with individual health plans and states, a common theme that the LAN uncovered is that plans are eager to analyze their own business using the APM Framework as a guide, and they find internal value from participating in a measurement effort. Individual data analysis assists health plans and states with their own strategic planning based on the unique situations of their markets, which can lead to innovations designed to improve care quality and affordability.

Value in Customization

Healthcare is local, and each market is unique, which means some health plans and states may take more aggressive approaches than others in the move toward alternative payment models; other health plans and states may feel they have less opportunities to experiment. The LAN learned that direct comparisons between health plans and across states or geographies are inappropriate because each plan and state deals with a unique set of market dynamics related to supply and demand, urban and rural environments, provider or plan readiness, and more. Still, there is value in understanding the facilitators and barriers to adoption of APMs in the different market segments. This year's effort shows the differences in APM adoption even more acutely by line of business – commercial, Medicaid, Medicare Advantage, and Medicare FFS – which can lead to greater insight into the similarities and differences in payment activity between them.

Value in the Common Framework

State Medicaid agencies from eight states use the LAN Framework to define the level and type of alternative payment models in their state's Medicaid program.²⁰ State-level APM measurement is taking place in both the Medicaid and commercial sectors. States, specifically state regulators, are likely to have unique needs and desired outcomes, and the LAN APM Framework provides a consistent foundation on which to measure state-specific implementation of APMs. The LAN looks forward to working with more states in future measurement efforts and collaborating on how the APM Framework can help track state-specific APM adoption goals.

Looking Forward

The LAN APM Measurement Efforts demonstrate the significant progress health plans and states have made in moving to APMs as a means to improve quality and contain costs.

The LAN encourages health plans, states, and other stakeholders to contribute to our national understanding of APM adoption by collaborating in future LAN APM Measurement Efforts. It is through

²⁰ Davis, H.E., and Boozang, P.M., "Leveraging Medicaid Managed Care to Advance Value-Based Payment" Manatt on Health: Medicaid Edition, May 2018 <https://www.manatt.com/Insights/Newsletters/Manatt-on-Health-Medicaid-Edition/Leveraging-Medicaid-Managed-Care-to-Advance-Value>

the collective efforts of the public and private sector that momentum continues to build around APM adoption and experimentation to improve healthcare quality and affordability for all Americans.

To learn more about the LAN's APM Measurement Efforts, please visit the [LAN website](#).

ⁱ The Healthcare Payment Learning Action Network was created through the Centers for Medicare and Medicaid Services (CMS) Alliance to Modernize Healthcare (CAMH) Federally Funded Research and Development Center, which is operated by the MITRE Corporation.

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