APM MEASUREMENT EFFORT

Commercial health plans, Managed Care Organizations (MCOs), state Medicaid agencies, Medicare Advantage (MA) plans, and Traditional Medicare voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN’s 2030 goals by line of business.

In 2021, 19.6% of U.S. health care payments, flowed through Categories 3B-4 models. In each market, Categories 3B-4 payments accounted for:

- Commercial: 2.6% (Category 4), 10.1% (Category 3B), 21.8% (Category 3A), 65.5% (Category 1 & 2)
- Medicare Advantage: 12.7% (Category 4), 25.3% (Category 3B), 9.9% (Category 3A), 43.2% (Category 1 & 2)
- Traditional Medicare: 35.2% (Category 4), 5.9% (Category 3B), 18.1% (Category 3A), 59.8% (Category 1 & 2)
- Medicaid: 24.0% (Category 4), 7.8% (Category 3B), 8.8% (Category 3A), 59.9% (Category 1 & 2)

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 APM spending (Categories 3B, 4A, 4B, 4C) by line of business since 2018.

Categories 3-4 Spending By Year and by Line of Business: Data Years 2015-2021

Categories 3B-4 Spending By Year and Line of Business: Data Years 2018-2021

The LAN began collecting APM spending by LOB and subcategory in 2018 (2017 data year), however, not all plans that were surveyed in 2018 (2017 data year) included a breakdown of expenditures by subcategory. Therefore the subcategory breakdown is not shown in the above graphic.
What specific SDoH or delivery strategies are intended to improve?

Is your Plan leveraging value-based provider arrangements to incentivize providers to improve health equity through the following strategies?

### HEALTH EQUITY

- **Collection of standardized race, ethnicity, and language data**: 46%
- **Participation in quality improvement collaboratives**: 40%
- **Measurement of clinical outcome inequities among member groups**: 29%
- **Reporting performance measures by race, ethnicity, and language**: 22%
- **Reduction of clinical outcome inequities among member groups**: 22%
- **Collection of sexual orientation, gender, and identity data**: 21%
- **Participation in implicit bias (or similar) training**: 18%
- **Complete staff competencies to serve diverse populations**: 15%
- **Collection of disability status**: 7%
- **Blank/did not answer**: 6%
- **Collection of veteran status**: 4%
- **Other**: 3%

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

**Categories Payers Feel Will Increase the Most**

<table>
<thead>
<tr>
<th>Will APM adoption result in...</th>
<th>Strongly Agree/Agree</th>
<th>Strongly Disagree/Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better quality of care?</td>
<td>96%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>More affordable care?</td>
<td>82%</td>
<td>6%</td>
<td>10%</td>
</tr>
<tr>
<td>Improved care coordination?</td>
<td>96%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>More consolidation among health care providers?</td>
<td>41%</td>
<td>37%</td>
<td>21%</td>
</tr>
<tr>
<td>Higher unit prices for discrete services?</td>
<td>10%</td>
<td>56%</td>
<td>34%</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. Government influence
3. Provider interest/readiness