HCP-LAN GOAL STATEMENT FAQs

The Health Care Payment Learning & Action Network (LAN) is committed to advancing key objectives for the health care system: higher quality, enhanced patient experience, and health equity at lower cost. The LAN views adoption of two-sided risk alternative payment models (APMs) as key to these objectives, and recognizes that different markets and lines of business are progressing at different rates. To that end, the LAN has established new goals for adoption of two-sided risk APMs.

OUR GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

Q. HOW ARE THE 2020 LAN GOALS DIFFERENT FROM THE PRIOR LAN GOALS?

A. The prior LAN goals were based on adoption of APMs, including APMs with shared savings (Category 3A). By contrast, the new LAN goals are based on adoption of two-sided risk APMs (Categories 3B and 4), and do not include APMs with shared savings only. These categories are based on the LAN APM Framework depicted in Figure 1 below.

Q. WHAT DOES TWO-SIDED RISK MEAN?

A. Two-sided risk APMs are APMs that include upside gain and down-side risk, and appear in Categories 3B and 4. Two-sided APMs do not include shared savings-only models.

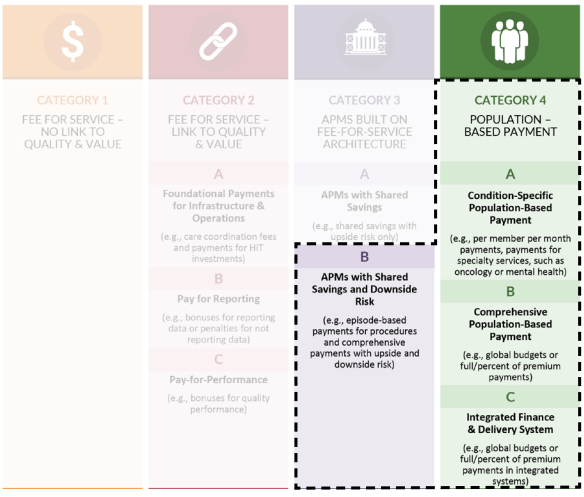

Figure 1

Q. WHY DID THE LAN SHIFT ITS FOCUS TO ADOPTION OF TWO-SIDED RISK APMs?

A. Current rates of health care spending will soon become unsustainable, and there is an urgent need to substantially transform the way that health care is paid for and delivered. Two-sided risk APMs hold promise for driving this fundamental change, because they promote incentives and flexibility to innovate and improve care delivery.

Q. ARE THE LAN GOALS REALISTIC, PARTICULARLY SINCE THE PREVIOUS LAN GOALS WERE NOT MET?

A. The LAN goals are ambitious but achievable if stakeholders across the public and private sectors commit to meeting them, and take concerted action to do so. The boldness of the goals is commensurate with the need to transform the health care system so that it delivers better outcomes at lower costs. These goals need to be achieved, and the LAN can help secure and align the commitments needed to achieve them.

Q. HOW WILL MODELS WITH TWO-SIDED RISK APMS BE MEASURED?

A. Adoption of two-sided risk APMs will continue to be measured through the LAN's annual measurement effort, in which the LAN invites health plans across market segments, as well as state Medicaid agencies, to quantify the amount of in- and out-of-network spending that flows through APMs. Participating plans and states categorize payments according to the LAN's APM Framework using the LAN survey tool, definitions, and methodology. Two-sided risk APMs correspond to results for Categories 3B and all of Category 4, and the LAN is exploring the possibility of updating the LAN APM Framework to incorporate nominal risk criteria for 3B—Shared-Risk APMs.

Q. WHAT IS NOMINAL RISK?

A. Nominal risk is a minimum risk threshold used along with other criteria in the Quality Payment Program to evaluate whether an APM qualifies as an Advanced Alternative Payment Model (AAPM). Nominal risk is defined as at least 3 percent of expected expenditures (benchmark-based standard) or 8 percent of average expected revenue (revenue-based standard).

Q. HOW IS NOMINAL RISK MEASURED?

A. In the summer and fall of 2019, the LAN piloted a two-sided risk metric to determine whether spending in two-sided models with less than nominal risk could be differentiated from spending in two-sided models with more than nominal risk. This metric may be included in subsequent measurement efforts, beginning as early as the LAN's 2020 measurement effort.

Q. WHY IS IT IMPORTANT TO MEASURE APM ADOPTION BY LINE OF BUSINESS?

A. It is important to measure APM adoption by line of business because different lines of business experience different types of challenges with APM adoption, and because there is variation in rates of adoption across lines of business. Due to this variability across lines of business, the LAN has set goals that are specific to each line of business to better monitor progress and identify strategies and solutions.

Q. WHICH TYPES OF PAYMENTS WILL LIKELY BE INCLUDED FOR THE PURPOSES OF MEASURING MEDICAID PAYMENTS?

A. For the purposes of future measurement efforts, the Medicaid market segment will likely be similarly defined to the current measurement effort, which includes both business health plans (MCOs) have with a state to provide health benefits to Medicaid eligible individuals and state-run programs themselves. Data submitted for future surveys will also likely exclude the following: health care spending for dual-eligible beneficiaries (dual-eligible payments are reported in other lines of business), health care spending for long-term services and supports (LTSS), and spending for dental and vision services. Responses to future surveys will reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible). Plans that specialize in LTSS provide unique services and may be included in future APM measurement efforts.

Q. WHICH TYPES OF PAYMENTS WILL LIKELY BE INCLUDED FOR THE PURPOSES OF MEASURING TRADITIONAL MEDICARE PAYMENTS?

A. For the purposes of future measurement efforts, the APMs CMS will use to calculate the percent of payments made through categories 3B and 4 of the APM Framework will include APMs that qualify as Advanced Alternative Payment Models (AAPMs). The most recent CMS Office of the Actuary (OACT) annual Part A and B expenditure data are used to calculate the denominator and are obtained directly from OACT. However, the future survey will likely exclude all or a proportion of spending associated with part A and B spending that is not readily linked to AAPMs, such as clinical laboratories, ambulance, Federally Qualified Health Centers, and rural health clinics.