APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS

LAN Insights into APM Adoption

HCP LAN
Health Care Payment Learning & Action Network

2017

LAN Insights into APM Adoption

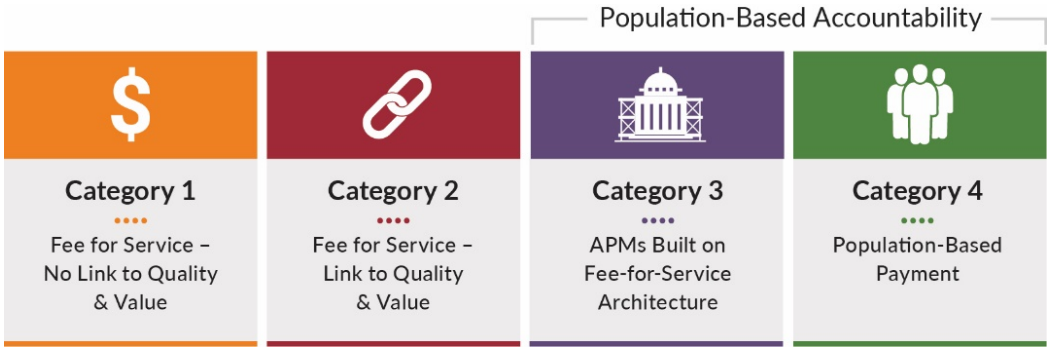
At its inception in 2015, the Health Care Payment Learning and Action Network (LAN)[i] adopted the goal to shift 30% of U.S. health care payments into alternative payment models (APMs) by 2016 and 50% by 2018. The LAN recently released results of this year's APM Measurement Effort, which demonstrates that 29% of health care payments in 2016 were made through alternative payment models – that is, shared savings, shared risk, bundled payments, or population-based payments. These results show that the nation has nearly achieved the LAN's 30% goal, compared to 23% the previous year, and represents a significant advancement on the proportion of payments in these models. What follows is an exploration of the insights into this progress and lessons learned from measurement.

Results

The LAN's annual APM Measurement Effort has captured payments made in calendar years (CY) 2015 and 2016 to date. To accomplish this, the LAN invited health plans and states from across the nation to report payments made to providers according to the original LAN APM Framework. At a high level, the categories include:

- Category 1: Traditional fee-for-service or other legacy payments not linked to quality
- Category 2: Pay-for-performance or care coordination fees
- Categories 3 and 4: Shared savings, shared risk, bundled payments, or population-based payments

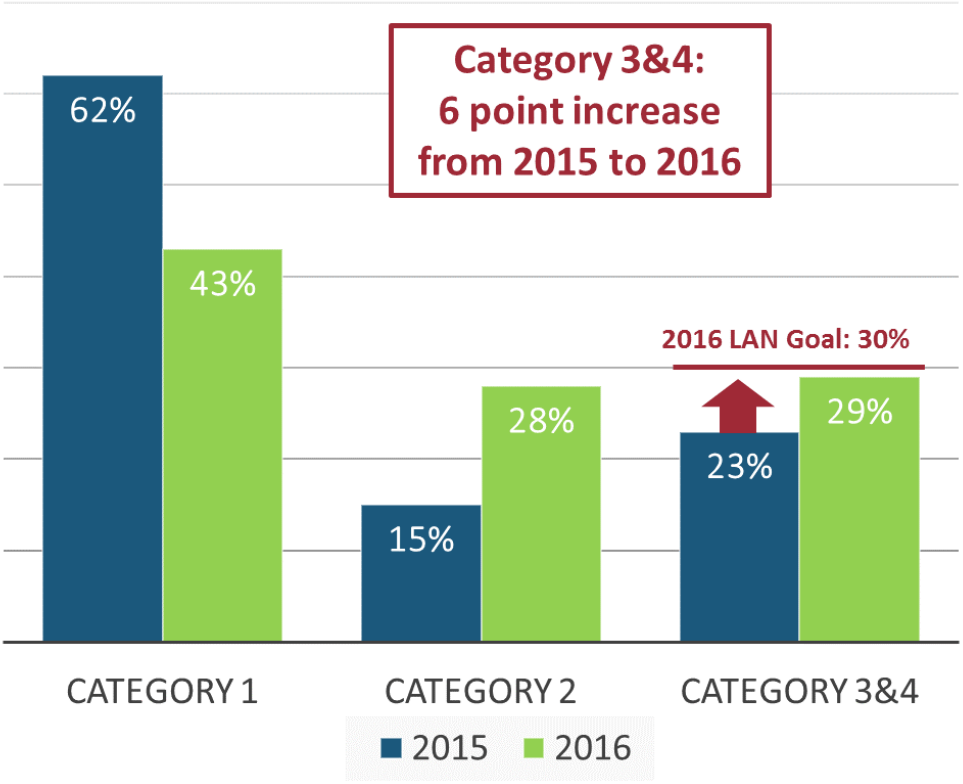
Figure 1: Original APM Framework



In both years, the LAN collaborated with the Blue Cross Blue Shield Association (BCBSA) and America's Health Insurance Plans (AHIP), which both conducted their own APM surveys, to gather representative data on the type of payments health plans with commercial, Medicare Advantage, and Medicaid business made to health care providers. The LAN also collaborated with the Centers for Medicare and Medicaid Services (CMS) and the National Association of Medicaid Directors (NAMD) to collect this data from FFS Medicare and managed FFS Medicaid

states, respectively[1]. In addition, the Association for Community Affiliated Plans (ACAP) and the Alliance of Community Health Plans (ACHP) encouraged their member plans' participation in the LAN effort.

Figure 2: LAN APM Measurement Effort Results: Comparison between 2015 and 2016 payments:



This figure compares the data from CY 2015 to CY 2016. 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. Whereas in 2016, the data was collected by 78 plans, 3 managed FFS Medicaid states, and FFS Medicare. This represented 245.4 million lives or 84% of the U.S covered population.

Interpreting the Results

In comparing the results of this year's survey to the prior year (Figure 2), adoption of Category 3 and 4 APMs increased by six percentage points, bringing total APM spending to approximately $354.5 billion dollars nationally. While these models are the LAN's primary focus, it is also important to note the increase in Category 2. What accounts for the growth in Categories 3 and 4 as well as the significant increase in Category 2?

[1] 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.

Increased Accountable Care Organization (ACO) Penetration

It is reasonable to assume that the increasing prevalence of ACOs contributes to the increase in Categories 3 and 4. Over the past year in the public sector, Medicare has launched its Next Generation ACO program, and more health systems, hospitals and provider groups are joining the Medicare Shared Savings Program (MSSP).[2] In addition, there has been a growth in ACOs in the private sector. From the first quarter of 2016 to the first quarter of 2017, 92 organizations became ACOs, bringing the nationwide total to 923.[3] Many payment arrangements with ACOs start with a shared savings approach, which falls into APM Framework Category 3. In addition, many ACO contractual arrangements move to shared risk payments (also Category 3) after a few years of operating under shared savings arrangements.

Legislation

The 2015 Medicare Access and CHIP Reauthorization Act (MACRA) established significant financial incentives for physicians to participate in Advanced APMs. These incentives have likely accelerated participation in advanced APMs within Categories 3 and 4.

While not directly related to Categories 3 and 4, this year's increase in Category 2 payments and decrease in Category 1 payments could also signal that a greater proportion of health care payments are transitioning away from traditional legacy payment systems that have no link to quality performance, such as fee-for-service or diagnosis-related groups. Many providers who do not exceed the minimum threshold of Advanced APM participation to qualify for MACRA incentives will be paid through the Merit-based Incentive Payment System (MIPS) in 2019, which will likely extend this trend.

FFS Medicare Impact

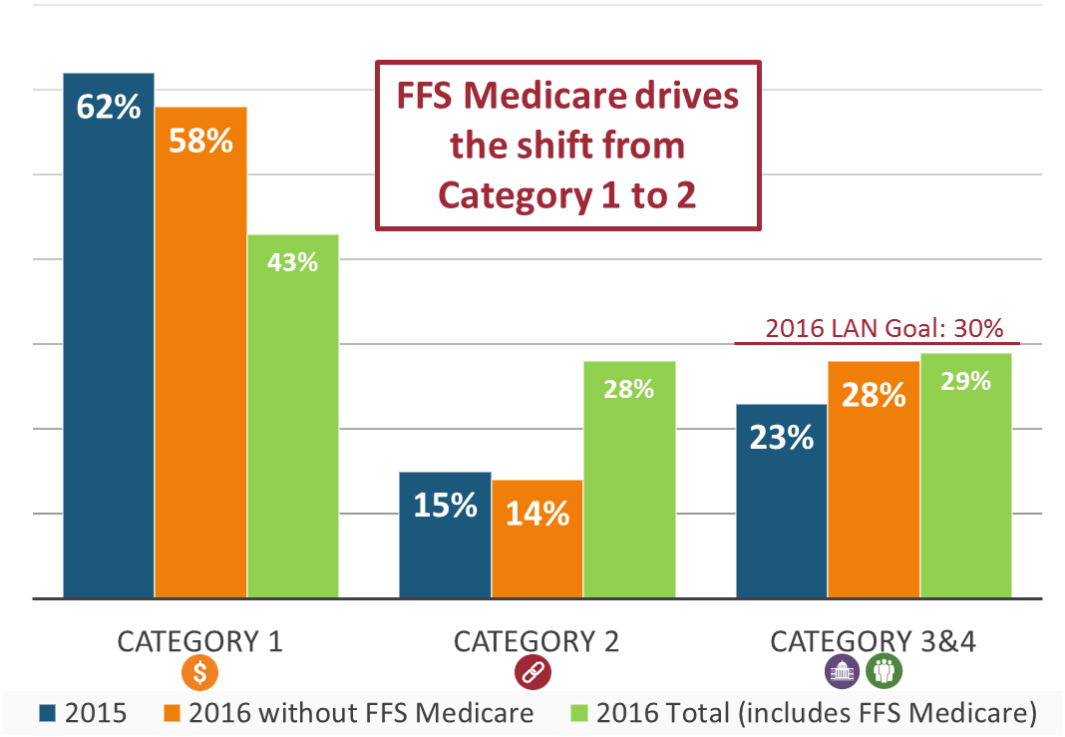
The growth in Category 2 payments is in part due to the inclusion of FFS Medicare data in this year's measurement effort, primarily because FFS Medicare has operated Category 2 Hospital Value-Based Purchasing programs and other value-based programs since 2013. If we remove FFS Medicare payments in order to have more comparable data sets, Category 1 payments decrease from 62% last year to 58% this year (rather than 43%), and Category 2 payments also decrease from 15% to 14% (rather than increase to 28%). However, the removal of FFS

[2] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-11-2.html

[3] http://healthaffairs.org/blog/2017/06/28/growth-of-acos-and-alternative-payment-models-in-2017/

Medicare data does not significantly affect the percent of payments in Categories 3 and 4, which increased to 28% in 2016 without FFS Medicare data (rather than 29%).

Figure 3: Comparison between 2015 and 2016 payments: Without FFS Medicare



Lessons Learned

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

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. However, myriad variations in health plan programs means 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 the 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 future measurement efforts will help address these issues, and minimize variation in interpretations and approaches.

Second, 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 gleaned 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.

Third, health care is local and each market is unique, which means some health plans and states may take a more progressive approach than others in the move toward alternative payment models; other health plans and states may feel they have less opportunity to experiment. The LAN learned that direct comparisons between health plans and across states or geographies are inappropriate because each plan and state is dealing with a unique set of market dynamics related to supply and demand, urban and rural environments, provider or plan readiness and the like. That said, there is value in understanding the facilitators and barriers to adoption of APMs in the different market segments. This year's effort reflects trends across market segments – commercial, Medicaid, Medicare Advantage, and FFS Medicare – and future measurement efforts will likely lead to greater insight into the similarities and differences in payment activity between them.

Finally, the LAN is encouraged by states' interest in both in the APM Framework and in applying the principles for state-specific measurement. 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 being made by health plans and states across the nation in moving to APMs as a means to improve quality and contain costs. As it moves toward the 2018 goal of 50% APM adoption, the LAN will continue to track the nation's progress by capturing CY 2017 data in next year's LAN APM Measurement Effort, again with the collaboration of AHIP and BCBSA as well as states. Payment reform is evolving, and next year's effort will incorporate the refresh of the LAN APM Framework in 2017 that reflects recent market changes and legislation—for example, changes in payments to primary care physicians through patient-centered medical homes and the introduction of the Comprehensive Primary Care Plus Model (CPC+).

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

To learn more about the LAN's APM Measurement Efforts, please visit the LAN website.

[i] The Health Care 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.