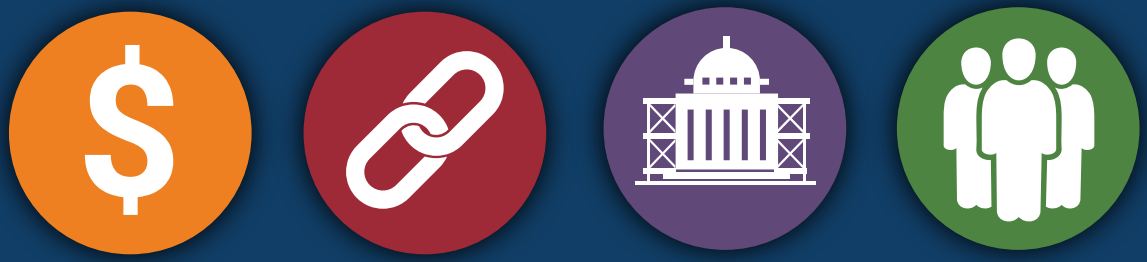
APM MEASUREMENT

PROGRESS OF ALTERNATIVE PAYMENT MODELS



2019 Methodology and Results Report

HCPLAN

Health Care Payment Learning & Action Network

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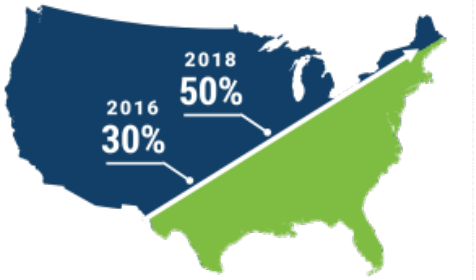
Overview

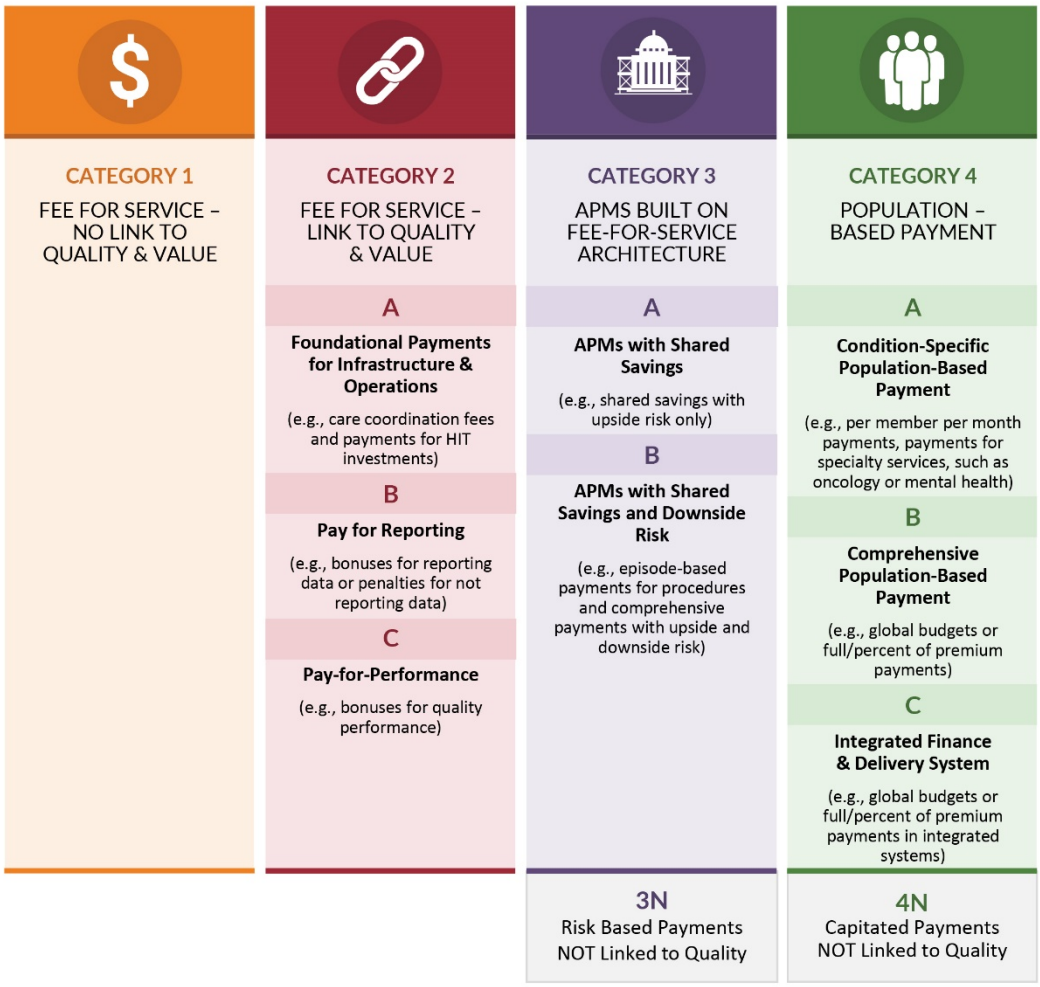
Alternative payment models (APMs) have the potential to realign payment incentives and care delivery to improve health care quality while reducing costs. In 2015, the U.S. Department of Health & Human Services (HHS) announced a goal of tying 30% of fee-for-service (FFS) Medicare payments to quality or value through APMs by 2016 and 50% by 2018. These goals are expected to accelerate the adoption and dissemination of meaningful financial incentives that reward providers who deliver higher value care.

The Health Care Payment Learning & Action Network (LAN), created to accelerate APM adoption and drive alignment in payment reform approaches across the public and private sectors, adopted and applied these goals to the LAN's ongoing initiative. Three years ago, the LAN embarked on its first national APM Measurement Effort to assess the adoption of APMs in the commercial, Medicare Advantage, and Medicaid market segments across the country, with the intention to measure progress toward the goals and to examine how APM adoption is changing over time. The LAN's APM Measurement Effort described in this report marks the fourth year of this initiative, and the second year where results for the commercial, Medicaid, Medicare Advantage, and Traditional Medicare market segments are each reported separately.



The LAN invited health plans across market segments, as well as FFS Medicaid states, to quantify the amount of in- and out-of-network spending that flows through APMs, including key areas of pharmacy and behavioral health spending, if such data were available. Participating plans and states categorized payments according to the LAN's APM Framework (which was refreshed in 2017), using the LAN survey tool, definitions, and methodology (Figure 1).

Figure 1: LAN APM Framework



All four LAN APM Measurement Efforts requested health plans and states to provide retrospective data of actual dollars paid to providers during the previous calendar year (CY) or the most recent 12-month period for which the data were available. In 2018, the results demonstrated the following for payments made during CY 2017:

- 41% of health care dollars in Category 1;
- 25.4% of health care dollars in Category 2;
- 29.8% of health care dollars in Category 3; and
- 3.8% of health care dollars in Category 4.

A total of 61 health plans, 3 FFS Medicaid states, and Traditional Medicare participated in last year's effort, representing approximately 226.3 million of the nation's covered lives and 77% of the national market. More information on 2017 payment results can be found in last year's 2018 APM Measurement Effort report.

This Year's APM Measurement Effort

To determine the best method of data collection for the 2019 APM Measurement Effort, the LAN revisited the data collection process used in the past three years. The LAN once again collaborated with America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association (BCBSA), and the Centers for Medicare and Medicaid Services (CMS), requesting data from health plans, states, and the Traditional Medicare program. Similar only to the 2018 effort, the four organizations (the LAN, AHIP, BCBSA, and CMS) included five supplemental, informational questions about the future of APM adoption and collected payment data by line of business (i.e., commercial, Medicaid, Medicare Advantage, and Traditional Medicare), and at the payment level within the various subcategories (e.g., pay-for-performance, shared risk). The organizations believe that this more granular data provides more actionable insights into the state of APMs in the commercial, Medicaid, Medicare Advantage, and Traditional Medicare markets, and that qualitative insights collected through the informational questions help enhance the quantitative results by identifying the potential future trajectory of APMs.

To better reflect the activities in the market, the LAN made a few updates to the APM Measurement Effort survey. These updates include the following: an expansion to the definition of integrated financial and delivery system programs (subcategory 4C); [1] the addition of a follow-up question to capture the types of payment arrangements through which dollars in integrated financial and delivery system programs flow between payers and providers; the recategorization of Population-based Payments that are NOT Condition-

[1] In the 2018 Measurement Effort, in order for claims dollars to be counted toward 4C, ownership between an insurer and delivery system needed to exist. In addition to ownership, the 2019 Measurement Effort offers two additional ways for dollars to be counted toward 4C: the payer and provider organizations share a common governance structure, or the payer and provider organizations are engaged in mutually exclusive relationships. See Appendix A: Definitions.

specific from subcategory 3B to subcategory 4B;[2] and minimal updates to the informational questions.[3] These changes were made in consultation with AHIP, BCBSA, CMS, and individual payers who are familiar with the Measurement Effort. All entities agreed to make adjustments to the data collection approach, and all changes were communicated to participating payers during training webinars and through the Frequently Asked Questions resource for participating payers.

In this year's effort, 62 health plans, 7 FFS Medicaid states, and Traditional Medicare, representing approximately 226.5 million of the nation's covered lives and 77% of the national market, participated in the data collection at the subcategory level. The percentage of the national market is based on a denominator of approximately 296 million lives covered by any health insurance plan.[4]

This year's LAN APM Measurement Effort combines data from the BCBSA survey, the AHIP survey, and the LAN survey, in addition to Traditional Medicare data, which was submitted separately to the LAN. Health plans, states, and Traditional Medicare reported the total dollars paid to providers through the payment methods within the subcategories according to the refreshed LAN APM Framework. With this data, the LAN calculated aggregate results by line of business and at the payment method level by category and subcategory.

Scope

Certain items were not included in the scope of the study but could be considered for future measurement efforts. Specifically, this year's LAN APM Measurement Effort did not include or address the following:

Reporting on Incentives: The LAN is interested in measuring the amount of financial incentives to providers. However, according to health plans, this information is difficult to collect, as incentive payments are often made in the year following the reporting period. Some health plans also indicated challenges with breaking out incentive amounts from any base payment, particularly if they offer multiple forms of incentives to a provider.

Reporting on Downside Risk: The LAN is interested in measuring whether or not dollars flowing through payment methods with provider downside risk (i.e., all payments in subcategories 3B and above) are flowing through contracts that meet certain "nominal risk" specifications, drawing from those outlined in the CMS Quality Payment Program (QPP) for determining Advanced Alternative Payment Models (AAPMs). To explore the possibility of incorporating this analysis into future APM Measurement Efforts, the LAN engaged AHIP, BCBSA, the Center for Medicare & Medicaid Innovation (CMMI), and approximately 15 national, regional, and

[2] Previously these payments were labeled as Subcategory 3B, but the LAN now recognizes them as 4B payments. The definition of this payment category has been expanded to clarify that the services for which the payment provides coverage is predefined and could cover primary, acute, and post-acute care that is not specific to any particular condition.

[3] The most significant change is that a new answer choice, "Interoperability," has been added to the Barriers and Facilitators questions. Other updates served clarification purposes only.

[4] U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement. Available at https://www.census.gov/library/publications/2019/demo/p60-267.html. Accessed September 27, 2019.

public state payers in a workgroup tasked with developing a parsimonious set of metrics to measure the levels of downside risk in APM categories 3B, 4A, 4B, and 4C in all market segments (commercial, Medicaid, Medicare Advantage, and Traditional Medicare).

How Payments Affect Providers Downstream: The LAN has expressed interest in uncovering how APM incentives flow to individual health care providers. However, this information is also difficult to collect, as health plans do not always know how their contracted health systems, hospitals, and/or physician practices pay individual providers. We do know, however, that organizations that receive Category 4 payments have widely varying philosophies about the extent to which they pass such payments along to individual providers.

Certain Medicare and Medicaid Services: This APM measurement effort does not include health care spending for Medicaid long-term services and supports (LTSS) or dual-eligible beneficiaries. Plans that specialize in LTSS provide unique services and may be included in future APM measurement efforts. Furthermore, dual-eligible beneficiaries and spending were excluded from Medicaid submissions to mitigate the possibility of double-counting, but were included in Medicare Advantage submissions. Medicare supplement plans and spending were excluded, as they are not part of Medicare Advantage or the commercial market.

Data Source

To advance our understanding of the depth and breadth of payment innovation, the LAN capitalized on existing networks and forged new partnerships to increase awareness and engage additional health plans and states. In addition to partnering with BCBSA and AHIP, the LAN collaborated with several other associations to invite their respective members to directly participate in this effort and to support recruitment. These organizations included the Association for Community Affiliated Plans (ACAP), the Alliance for Community Health Plans (ACHP), and the National Association of Medicaid Directors (NAMD). The LAN also leveraged its communication tools (e.g., website and newsletter) and events (e.g., LAN Summit) to reach broader audiences and to promote the measurement effort among those health plans and states with existing ties to the LAN.

Health plans had multiple paths to contribute to the LAN APM Measurement Effort. In addition to the LAN's data collection efforts (see the LAN Survey section below), BCBSA and AHIP fielded surveys to their member health plans and structured their queries according to the refreshed LAN APM Framework. A coordinated health plan outreach strategy ensured that health plans only responded to one survey, which avoided issues related to double-counting. All three avenues of data collection requested that health plans report the total dollars paid to providers by line of business and at the payment method level.

Additionally, CMS submitted Traditional Medicare data to the LAN to be aggregated with health plan and state data.

The LAN Survey

The most recent LAN data collection period started on June 10, 2019, and ended on July 26, 2019. The LAN calculated metrics capturing the extent of APM adoption, based on requests to health plans and states to report dollars paid in either CY 2018 or in the most recent 12 months for which it had data. Health plan and

state participation, as well as individual data, were kept confidential. Health plans participating through the LAN had the opportunity to execute a data-sharing agreement with the MITRE Corporation as the operator of the CMS Alliance to Modernize Healthcare (Health FFRDC).[5] In order to maintain HHS' impartiality and participant confidentiality, Health FFRDC, and not HHS, received, analyzed, and aggregated all individual plan and state data. The role of the MITRE Corporation is discussed more fully in Appendix B.

Because most payment innovations typically incorporate multiple payment methods (e.g., FFS plus a care coordination fee and shared-savings), plans and states were asked to report dollars paid according to the most dominant or advanced payment method they used (e.g., shared-savings or condition-specific population-based payments). The Health FFRDC reviewed health plan responses to identify outlier or inconsistent data and provided follow-up questions to plans and states to support data integrity. Health plans and states either clarified or modified their responses as appropriate.

The method for calculating the metrics required health plans and states to retrospectively examine the actual payments they made to providers in CY 2018 (or in the most recent 12 months for which it had data) through the different APMs and categorize them accordingly. For APMs in Categories 3 and 4, some of which hold providers accountable for their patients' total cost of care, health plans could report dollars paid based on members attributed to the method.[6]

The data collected through the LAN survey are described in Table 1 and Table 2. AHIP and BCBSA collected data identical to that collected through the LAN survey (see Blue Cross Blue Shield Association Survey and America's Health Insurance Plans Survey sections below).

[5] The CMS Alliance to Modernize Healthcare (CAMH) is a Federally Funded Research and Development Center (FFRDC), convened to independently manage the LAN.

[6] For more information and guidance on categorizing payments, including capitation without quality, see the National APM Data Collection Frequently Asked Questions for 2019.

Table 1: 2019 Quantitative Survey Data

DENOMINATOR	DESCRIPTION OF METRIC
Total dollars paid to providers (in and out of network) for members in CY 2018 or most recent 12 months.	*Denominator to inform the metrics below.*

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 1 (METRICS ARE NOT LINKED TO QUALITY)	
Total dollars paid to providers through **legacy payments** (including fee-for-service, diagnosis-related groups, or capitation without quality components) in CY 2018 or most recent 12 months.	Dollars under legacy payments (including fee-for-service, diagnosis-related groups, or capitation without quality components): Percent of total dollars paid through legacy payments in CY 2018 or most recent 12 months.
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 2 (ALL METRICS ARE LINKED TO QUALITY)	
Dollars paid for **foundational spending** to improve care (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 2A)	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2018 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-reporting** payments (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 2B)	Dollars in pay-for-reporting programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2018 or most recent 12 months.
Total dollars paid to providers through **fee-for-service plus pay-for-performance** payments (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 2C)	Dollars in pay-for-performance programs: Percent of total dollars paid through fee-for-service plus pay-for-performance (linked to quality) payments in CY 2018 or most recent 12 months.
Total dollars paid in **Category 2** in CY 2018 or most recent 12 months.	Payment Reform – APMs built on fee-for-service linked to quality: Percent of total dollars paid in Category 2.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 3 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **traditional shared-savings** (linked to quality) payments in CY 2018 or most recent 12 months. (Subcategory 3A)	Dollars in traditional shared-savings (linked to quality) programs: Percent of total dollars paid through traditional shared-savings payments in CY 2018 or most recent 12 months.
Total dollars paid to providers through **utilization-based shared-savings** (linked to quality) payments in CY 2018 or most recent 12 months. (Subcategory 3A)	Dollars in utilization-based shared-savings (linked to quality) programs: Percent of total dollars paid through utilization-based shared-savings payments in CY 2018 or most recent 12 months.
Total dollars paid to providers through **fee-for-service-based shared-risk** (linked to quality) payments in CY 2018 or most recent 12 months. (Subcategory 3B)	Dollars in fee-for-service-based shared-risk programs: Percent of total dollars paid through fee-for-service-based shared-risk (linked to quality) payments in CY 2018 or most recent 12 months.
Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2018 or most recent 12 months. (Subcategory 3B)	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2018 or most recent 12 months.
Total dollars paid in **Category 3** in CY 2018 or most recent 12 months.	Payment Reform – APMs built on fee-for-service architecture: Percent of total dollars paid in Category 3.

NUMERATOR	DESCRIPTION OF METRIC
ALTERNATIVE PAYMENT MODEL FRAMEWORK—CATEGORY 4 (ALL METRICS ARE LINKED TO QUALITY)	
Total dollars paid to providers through **condition-specific, population-based payments** (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 4A)	Condition-specific, population-based payments (linked to quality): Percent of total dollars paid through condition-specific, population-based payments (linked to quality) in CY 2018 or most recent 12 months.
Total dollars paid to providers through **condition-specific, bundled/episode payments** (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 4A)	Dollars in condition-specific, bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode payments (linked to quality) in CY 2018 or most recent 12 months.
Total dollars paid to providers through **population-based payments that are NOT condition-specific** (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 4B)	Population-based payments that are not condition-specific (linked to quality): Percent of total dollars paid through population-based payments that are not condition-specific (linked to quality) in CY 2018 or most recent 12 months.
Total dollars paid to providers through **full or percent of premium population-based payments** (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 4B)	Dollars in full or percent of premium population-based payment programs (linked to quality): Percent of total dollars paid through full or percent of premium population-based payments (linked to quality) in CY 2018 or most recent 12 months.
Total dollars paid to providers through **integrated finance and delivery system programs** (linked to quality) in CY 2018 or most recent 12 months. (Subcategory 4C)	Dollars through integrated finance and delivery programs (linked to quality): Percent of total dollars paid through integrated finance and delivery programs (linked to quality) in CY 2018 or most recent 12 months.
Total dollars paid in **Category 4** in CY 2018 or most recent 12 months.	Payment Reform – Population-based APMs: Percent of total dollars paid in Category 4.

PAYMENT METHOD BREAKDOWN OF INTEGRATED FINANCE AND DELIVERY SYSTEM PROGRAMS (4C) DOLLARS[7]	
If dollars are paid to providers through **integrated finance and delivery system programs** in CY 2018, please break down the percentage of those dollars flowing through each of the underlying payment methods the health plan uses to pay network providers.	• Salary • Legacy Payments • Foundational Spending to Improve Care • FFS plus Pay-for-Performance • Traditional Shared-Savings • Utilization-based Shared-Savings • FFS-based Shared Risk • Procedure-based Bundled/Episode Payments • Condition-specific Population-based Payments • Condition-specific Bundled/Episode Payments • Population-based Payments that are NOT Condition-specific • Full or Percent of Premium Population-based Payments

Table 2: 2019 Informational Questions

QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, what do you think will be the trend in APMs over the next 24 months?	• APM activity will increase • APM activity will stay the same • APM activity will decrease • Not sure
[To those who answered "APM activity will increase"] Which APM subcategory do you think will increase the most in activity over the next 24 months?	• Traditional shared-savings, utilization-based shared-savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure

[7] This metric was asked in the 2019 Measurement Effort, but results are not reported due to insufficient responses.

QUESTIONS	RESPONSE OPTIONS
[To those who answered "APM activity will decrease"] Which APM subcategory do you think will decrease the most in activity over the next 24 months?[8]	• Traditional shared-savings, utilization-based shared-savings (3A) • Fee-for-service-based shared risk, procedure-based bundled/episode payments (3B) • Condition-specific population-based payments, condition-specific bundled/episode payments (4A) • Full or percent of premium population-based payments, population-based payments that are not condition-specific (4B) • Integrated finance and delivery system programs (4C) • Not sure
From health plan's perspective, what are the top barriers to APM adoption? (Select up to 3)	• Provider interest/readiness • Health plan interest/readiness • Purchaser interest/readiness • Government influence • Provider ability to operationalize • Health plan ability to operationalize • Interoperability • Provider willingness to take on financial risk • Market factors • Other (please list)
From health plan's perspective, what are the top facilitators to APM adoption? (Select up to 3)	• Provider interest/readiness • Health plan interest/readiness • Purchaser interest/readiness • Government influence • Provider ability to operationalize • Health plan ability to operationalize • Interoperability • Provider willingness to take on financial risk • Market factors • Other (please list)

[8] This question was included in the 2019 Measurement Effort, but results are not reported due to insufficient responses.

QUESTIONS	RESPONSE OPTIONS
From health plan's perspective, please indicate to what extent you agree or disagree that APM adoption will result in each of the following outcomes:	• Better quality care (strongly disagree, disagree, agree, strongly agree, not sure) • More affordable care (strongly disagree, disagree, agree, strongly agree, not sure) • Improved care coordination (strongly disagree, disagree, agree, strongly agree, not sure) • More consolidation among health care providers (strongly disagree, disagree, agree, strongly agree, not sure) • Higher unit prices for discrete services (strongly disagree, disagree, agree, strongly agree, not sure) • Other (please list) (strongly disagree, disagree, agree, strongly agree, not sure)

The Blue Cross Blue Shield Association Survey

To collect the data points in Table 1 and Table 2, BCBSA included questions in an annual survey of member plans addressing the delivery of value-based health care. BCBSA collaborated with the LAN and AHIP to ensure alignment of survey questions to facilitate data aggregation.

BCBSA reported the data elements in Table 1 and Table 2, and those listed below, in aggregate to the LAN for the purposes of measuring multiple payers' adoption of APMs nationally:

- total number of participating plans, and
- total number of covered lives by participating plans.

The data elements listed above reflect 2018 data but were submitted to, validated by, and aggregated by BCBSA in the third quarter of 2019. Data were collected for health care spending paid to all providers for dates of service in CY 2018 (January 1 to December 31) or the most recent 12-month period, while the covered lives data point was requested as a "point in time" for December 31, 2018.

The America's Health Insurance Plans Survey

The 2019 surveys fielded by AHIP and LAN were identical. In late 2018 and early 2019, the LAN and AHIP worked together to make the previously described changes to the 2018 version for the current measurement effort, in order to reflect the metrics listed in Table 1 and Table 2. The survey was updated and administered through Qualtrics software (Qualtrics, Provo, UT). Questions focused on the dollars associated with APMs, as defined using the refreshed LAN APM Framework. AHIP member plans responded directly through AHIP. AHIP reported the same data elements as did BCBSA to the LAN for the purposes of measuring multi-payer adoption of APMs nationally.

Starting at the beginning of April 2019, AHIP embarked on a six-week recruitment program, which included repeated email and phone outreach to its member plans. Using a key informant approach, AHIP emailed survey invitations to chief medical officers, provider contracting leads, and payment innovation staff from their member plans, who then shared the survey with their teams, as appropriate. Data collection occurred from May through September 2019, and all responses were based on the plan's business activity during CY 2018.

After responses were received, AHIP contacted health plans with follow-up questions for clarifications as appropriate.

Traditional Medicare

CMS reported Traditional Medicare spending in CY 2018 to the LAN. CMS also collaborated with BCBSA, AHIP, and the LAN to align methodologies and facilitate data aggregation for reporting national progress. The CY 2018 Medicare Parts A & B data elements that were reported to the LAN are the data elements in Table 1, which include the total dollars paid to providers participating in Traditional Medicare APMs in CY 2018 by subcategory and category.

The Traditional Medicare results are considered interim because they are based on only two quarters of CY 2018 actual claims data. Due to claims run out and data lag issues, each quarter of actual claims data becomes available seven to eight months after the end of the quarter.[9]

The alternative payment models CMS used to calculate the percent of payments made through categories 3 and 4 of the APM Framework in CY 2018 include shared savings, shared risk, bundled payments, and population-based payment models. The most recent 2018 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.

Merging the Data

The LAN merged the data elements from the BCBSA and AHIP surveys, as well as those reported by Traditional Medicare, with those submitted directly to the LAN.

To avoid double counting, BCBSA, AHIP, and the LAN coordinated recruiting efforts. BCBSA asked member plans to participate directly through BCBSA, and AHIP asked member plans (that were not BCBSA plans) to participate through AHIP. Plans that were members of neither BCBSA nor AHIP had the opportunity to report through the LAN.

[9] The Traditional Medicare 2018 interim result will be updated with data from the final two quarters in CY 2018 as part of the President's Budget in the next CMS Congressional Justification, published in 2020.

Results: Payments Made in CY 2018

Results are presented by line of business (Aggregate, Commercial, Medicaid, Medicare Advantage, and Traditional Medicare) in the sections below.

Aggregate – All lines of business of respondents reporting at the subcategory level

The combined LAN, BCBSA, AHIP, and Traditional Medicare data, representing 77% of the national market[10], show the following subcategory level payments made to providers in CY 2018 in all lines of business:

CATEGORY 1	**TOTAL 39.1%**
CATEGORY 2	**TOTAL 25.1%**
• Foundational payments to improve care (2A)	**SUBTOTAL 0.2%**
• Fee-for-service plus pay-for-reporting payments (2B)	**SUBTOTAL 0.1%**
• Fee-for-service plus pay-for-performance payments (2C)	**SUBTOTAL 24.8%**
CATEGORY 3	**TOTAL 30.7%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	**SUBTOTAL 21.3%**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	**SUBTOTAL 9.4%**
CATEGORY 4	**TOTAL 5.1%**
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	**SUBTOTAL 1.8%**
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	**SUBTOTAL 2.9%**
• Integrated finance and delivery system programs (4C)	**SUBTOTAL 0.4%**
CATEGORIES 3 & 4, COMBINED	**TOTAL 35.8%**

[10] 62 health plans, 7 states, Traditional Medicare

INFORMATIONAL QUESTIONS				
PAYERS WHO THINK APM ACTIVITY:	***WILL INCREASE***	***WILL STAY THE SAME***	***WILL DECREASE***	***PAYERS WHO ARE NOT SURE/DECLINED TO RESPOND***
	91%	7%	0%	2%
PAYERS STATING THAT THE APM SUBCATEGORY THAT WILL INCREASE THE MOST WILL BE:				
• Fee-for-service-based shared-risk, Procedure based bundled/episode payments **(3B)**	**45%**			
• Traditional shared-savings, Utilization-based shared-savings **(3A)**	**31%**			
TOP THREE BARRIERS TO APM ADOPTION AS IDENTIFIED BY PAYERS				
1. Provider willingness to take on financial risk 2. Provider ability to operationalize 3. Provider interest/readiness				
TOP THREE FACILITATORS TO APM ADOPTION AS IDENTIFIED BY PAYERS				
1. Health plan interest/readiness 2. Government influence 3. Provider interest/readiness				
PAYERS WHO AGREE OR STRONGLY AGREE WITH AND PAYERS WHO DISAGREE OR STRONGLY DISAGREE WITH THE FOLLOWING:[11]	***AGREE/ STRONGLY AGREE***	***DISAGREE/ STRONGLY DISAGREE***		
• APM adoption will result in better quality of care	97%	2%		
• APM adoption will result in more affordable care	88%	4%		
• APM adoption will result in improved care coordination	95%	2%		
• APM adoption will result in more consolidation among health care providers	56%	19%		
• APM adoption will result in higher unit prices for discrete services	9%	63%		
• Other (please list)	0%	0%		

[11] The percents for each outcome do not add up to 100% because the "not sure" responses were removed from the data reported here.

Commercial

The commercial data, representing 133,533,413 covered lives, which is 61%[12] of the national commercial market, show the following for payments made to providers in CY 2018:

CATEGORY 1	**TOTAL 55.7%**
CATEGORY 2	**TOTAL 14.2%**
• Foundational payments to improve care (2A)	**SUBTOTAL 0.2%**
• Fee-for-service plus pay-for-reporting (2B)	**SUBTOTAL 0.1%**
• Fee-for-service plus pay-for-performance payments (2C)	**SUBTOTAL 13.9%**
CATEGORY 3	**TOTAL 27.6%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	**SUBTOTAL 19.5%**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	**SUBTOTAL 8.1%**
CATEGORY 4	**TOTAL 2.5%**
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	**SUBTOTAL 0.7%**
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	**SUBTOTAL 1.4%**
• Integrated finance and delivery system programs (4C)	**SUBTOTAL 0.4%**
CATEGORIES 3 & 4, COMBINED	**TOTAL 30.1%**

[12] U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement. Available at https://www.census.gov/library/publications/2019/demo/p60-267.html. Accessed September 27, 2019.

Medicaid

The Medicaid data, representing 31,783,556 Medicaid beneficiaries, which is 51% [13] of the national Medicaid market (excluding enrollees who are dually-eligible for Medicare and Medicaid coverage), show the following for payments made to providers in CY 2018:

CATEGORY 1	**TOTAL 66.1%**
CATEGORY 2	**TOTAL 10.6%**
• Foundational payments to improve care (2A)	**SUBTOTAL 1.1%**
• Fee-for-service plus pay-for-reporting (2B)	**SUBTOTAL <0.1%**
• Fee-for-service plus pay-for-performance payments (2C)	**SUBTOTAL 9.5%**
CATEGORY 3	**TOTAL 17.4%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	**SUBTOTAL 15.0%**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	**SUBTOTAL 2.4%**
CATEGORY 4	**TOTAL 5.9%**
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	**SUBTOTAL 1.9%**
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	**SUBTOTAL 3.9%**
• Integrated finance and delivery system programs (4C)	**SUBTOTAL 0.1%**
CATEGORIES 3 & 4, COMBINED	**TOTAL 23.3%**

[13] Source: CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," July 2019. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cms-fast-facts/index.html. Accessed October 1, 2019. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," September 23, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html. Accessed October 1, 2019.

Medicare Advantage

The Medicare Advantage data, representing 22,503,781 Medicare Advantage beneficiaries, which is 67%[14] of the national Medicare Advantage market (including enrollees who are dually-eligible for Medicare and Medicaid coverage), show the following for payments made to providers in CY 2018:

CATEGORY 1	**TOTAL 39.5%**
CATEGORY 2	**TOTAL 6.9%**
• Foundational payments to improve care (2A)	**SUBTOTAL <0.1%**
• Fee-for-service plus pay-for-reporting (2B)	**SUBTOTAL <0.1%**
• Fee-for-service plus pay-for-performance payments (2C)	**SUBTOTAL 6.9%**
CATEGORY 3	**TOTAL 36.4%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	**SUBTOTAL 29.3%**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	**SUBTOTAL 7.1%**
CATEGORY 4	**TOTAL 17.2%**
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	**SUBTOTAL 1.4%**
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	**SUBTOTAL 14.0%**
• Integrated finance and delivery system programs (4C)	**SUBTOTAL 1.8%**
CATEGORIES 3 & 4, COMBINED	**TOTAL 53.6%**

[14] Source: CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," July 2019. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cms-fast-facts/index.html. Accessed October 1, 2019. CMS Medicare-Medicaid Coordination Office, MMCO Statistical & Analytic Reports, "Annual (Medicare-Medicaid Duals) Enrollment Trends," September 23, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html. Accessed October 1, 2019.

Traditional Medicare

The Traditional Medicare data, representing 38,700,000 Traditional Medicare beneficiaries, which is 100%[15] of the Traditional Medicare market, show the following for payments made to providers in CY 2018:

CATEGORY 1	**TOTAL 10.2%**
CATEGORY 2	**TOTAL 48.9%**
CATEGORY 3	**TOTAL 36.5%**
• Traditional shared-savings, Utilization-based shared-savings (3A)	**SUBTOTAL 22.7%**
• Fee-for-service-based shared-risk, Procedure-based bundled/episode payments (3B)	**SUBTOTAL 13.8%**
CATEGORY 4	**TOTAL 4.4%**
• Condition-specific population-based payment, Condition-specific bundled/episode payments (4A)	**SUBTOTAL 3.4%**
• Population-based payments that are NOT condition-specific, Full or percent of premium population-based payments (4B)	**SUBTOTAL 1.0%**
• Integrated finance and delivery system programs (4C)	**SUBTOTAL 0%**
CATEGORIES 3 & 4, COMBINED	**TOTAL 40.9%**

[15] Source: CMS/Office of Enterprise Data & Analytics/Office of the Actuary, "CMS Fast Facts: CMS Program Data – Populations," July 2019. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/cms-fast-facts/index.html. Accessed October 1, 2019.

Limitations

Voluntary Health Plan and State Participation: The LAN data, combined with the BCBSA, AHIP, and Traditional Medicare data reported at the subcategory level, represent 77% of the covered lives in the U.S.. The Measurement Effort did not have full participation from all health plans and states, nor did it capture 100% of the lives covered by health insurance. Furthermore, health plan and state participation in the LAN, BCBSA, or AHIP surveys was voluntary. As a result, the findings may be biased by self-selection. Health plans and states actively pursuing payment reform may have been more likely to respond to the surveys, potentially driving Categories 2-4 results upward.

Potential Variation in the Interpretation of the Metrics: The LAN worked to facilitate a consistent interpretation of the APM categories, subcategories, and terms, as well as the methods for reporting through precise definitions, training sessions, written instructions, and discussions with individual health plans and states seeking clarification. However, the varying interpretation of the metrics could still create variability across data from individual health plans and states.

Data System Challenges: Some health plans and states reported data system challenges with reporting payment dollars according to the APM Framework, because developing new system queries and sorting data according to the APM categories and subcategories can be cumbersome. Such data system limitations can also result in health plans reporting data from an earlier 12-month period than CY 2018, which could reflect a lower level of APM adoption.

Appendix A: Definitions

The following terms and definitions were developed to provide consistent guidance for survey respondents. Some of the definitions are generally accepted, and others are specific only to the LAN and this APM measurement effort.

Table 3: Definitions

TERMS	DEFINITIONS
Alternative Payment Model (APM)	Health care payment methods that use financial incentives to promote or leverage greater value - including higher quality care at lower costs - for patients, purchasers, payers, and providers. This definition is specific to this exercise. MACRA uses a specific definition which can be found on the program's website. Refreshed APM Framework White Paper MACRA Website
Appropriate care measures	Appropriate care measures are metrics that are based on evidence-based guidelines and comparative effective research. Such measures assess how well providers avoid unnecessarily costly, harmful, and unnecessary procedures. These measures also address patients' goals, prognoses, and needs; and they reflect the outcome of shared decision-making among patients, caregivers, and clinicians (e.g., Choosing Wisely measures). Some examples of appropriate care measures include, but are not limited to, unnecessary readmissions, preventable admissions, unnecessary imaging, and appropriate medication use. Measures of appropriate care are required in order for a payment method to qualify as a Category 3 or 4 APM to ensure providers are incentivized to reduce/eliminate care that is wasteful and potentially harmful to patients. Appropriate care measures also ensure providers do not withhold necessary care and are incentivized to provide necessary care.
Category 1	 Fee-for-service with no link to quality. These payments utilize traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, or provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.

TERMS	DEFINITIONS
Category 2	 Fee-for-service linked to quality. These payments utilize traditional FFS payments but are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics.
Category 3	 APMs built on fee-for-service architecture. These payments are based on FFS architecture, while providing mechanisms for effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account, payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Providers who meet their quality, and cost or utilization targets are eligible to share in savings, and those who do not may be held financially accountable. Category 3 APMs must hold providers financially accountable for performance on appropriate care measures. See definition of "appropriate care measures" for a description and examples.
Category 4	 Population-based payment. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality, person-centered care within a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system. These models hold providers accountable for meeting quality and, increasingly, person-centered care goals for a population of patients or members. Payments are intended to cover a wide range of preventive health, health maintenance, and health improvement services, as well as acute and chronic care services. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Category 4 APMs require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.

TERMS	DEFINITIONS
Commercial Line of Business	The commercial market segment includes individual, small group, large group, fully insured, self-funded, and exchange business. To the extent a health plan provides benefits for the Federal Employee Health Benefit (FEHB) program, state active employee programs, and/or an exchange, this business is considered commercial and included in the survey. Survey data reflects dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2018 or the most recent 12-month period for which data is available. Spending for dental and vision services are excluded.
Commercial members/ Medicare Advantage members/ Medicaid beneficiaries	Health plan enrollees or plan participants.
Condition-specific bundled/episode payments	A single payment to providers and/or health care facilities for all services related to a specific condition (e.g., diabetes). The payment considers the quality, costs, and outcomes for a patient-centered course of care over a longer time period and across care settings. Providers assume financial risk for the cost of services for a particular condition, as well as costs associated with preventable complications. [APM Framework Category **4A**]
Condition-specific population-based payment	A per member per month (PMPM) payment to providers for inpatient and outpatient care that a patient population may receive for a particular condition in a given time period, such as a month or year, including inpatient care and facility fees. [APM Framework Category **4A**]
CY 2018 or most recent 12 months	Calendar year 2018 or the most current 12-month period for which the health plan can report payment information. This is the reporting period for which the health plan should report all of its "actual" spend data - a retrospective "look-back."

TERMS	DEFINITIONS
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients who are expected to have similar costs during a hospital stay - a form of case rate for a hospitalization. Each DRG is assigned a weight that reflects the relative cost of caring for patients in that category relative to other categories and is then multiplied by a conversion factor to establish payment rates.
Fee-for-service (FFS)	Providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes, or efficiency. [APM Framework Category **1**]
Foundational spending	Includes, but is not limited to, payments to improve care delivery such as outreach and care coordination/management; after-hour availability; patient communication enhancements; health IT infrastructure use. May come in the form of care/case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists. [APM Framework Category **2A**]
Full or percent of premium population-based payments	A fixed dollar payment to providers for all the care that a patient population may receive in a given time period, such as a month or year, (e.g., inpatient, outpatient, specialists, out-of-network, etc.) with payment adjustments based on measured performance and patient risk. [APM Framework Category **4B**]
Integrated finance and delivery system programs	Payments in which the delivery system is integrated with the finance system and delivers comprehensive care. These integrated arrangements consist of either insurance companies that own provider networks, or delivery systems that offer their own insurance products, or payer and provider organizations that share a common governance structure, or payer and provider organizations that are engaged in mutually exclusive relationships. See Frequently Asked Questions for more information. [APM Framework Category **4C**]
Legacy payments	Payments that utilize traditional payments and are not adjusted to account for infrastructure investments, provider reporting of quality data, or for provider performance on cost and quality metrics. This can include fee-for-service, diagnosis-related groups (DRGs), and per diems. [APM Framework Category **1**]

TERMS	DEFINITIONS
Linked to quality	Payments that are set or adjusted based on evidence that providers meet quality standards or improve care or clinical services, including for providers who report quality data, or providers who meet a threshold on cost and quality metrics. The APM Framework does not specify which quality measures qualify for a payment method to be "linked to quality" in Category 2. In order to qualify as a Category 3 or 4 APM, the link to quality must include “appropriate care measures.” See definition of “appropriate care measures” for a description and examples.
Medicaid Line of Business	The Medicaid market segment includes both business with a state to provide health benefits to Medicaid-eligible individuals and state-run programs themselves. Data submitted for this survey excludes the following: health care spending for dual eligible beneficiaries, health care spending for long-term services and supports (LTSS), and spending for dental and vision services. Survey data reflect dollars paid for medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2018 or the most recent 12-month period for which data is available.
Medicare Advantage Line of Business	The Medicare Advantage market segment includes a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, and Special Needs Plans. To the extent the Medicare Advantage plan has Part D or drug spending under its operations, it included this information in its response. Survey data reflect dollars paid for Medicare Advantage beneficiaries’ (including dual eligible beneficiaries) medical, behavioral health, and pharmacy benefits (to the extent possible) in CY 2018 or the most recent 12-month period for which data is available. Dental and vision services are excluded.
Pay-for-performance	The use of incentives (usually financial) to providers to achieve improved performance by increasing the quality of care and/or reducing costs. Incentives are typically paid on top of a base payment, such as fee-for-service or population-based payment. In some cases, if providers do not meet quality of care targets, their base payment is adjusted downward the subsequent year. [APM Framework Categories **2C**]

TERMS	DEFINITIONS
Population-based payment not condition-specific	A per member per month (PMPM) payment to providers for outpatient or professional services that a patient population may receive in a given time period, such as a month or year, not including inpatient care or facility fees. The services for which the payment provides coverage is predefined and could cover primary, acute, and post-acute care that is not specific to any particular condition. [APM Framework Category **4B**]
Procedure-based bundled/episode payment	Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g., hip replacement). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers assume financial risk for the cost of services for a particular procedure and related services, as well as costs associated with preventable complications. [APM Framework Categories **3B**]
Provider	For the purposes of the APM Measurement Effort, provider includes all providers for which there is health care spending. For the purposes of reporting APMs, this includes medical, behavioral, pharmacy, and DME spending to the greatest extent possible, and excludes dental and vision.
Shared-risk	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. [APM Framework Category **3B**]
Total Dollars	The total estimated in- and out-of-network health care spend (e.g., annual payment amount) made to providers in CY 2018 or the most recent 12 months for which data is available.

TERMS	DEFINITIONS
Traditional shared-savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a pre-established set target for spending, as long as they meet quality targets. Traditional shared-savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary spending for a defined population of patients or an episode of care, and to meet quality targets. [APM Category Framework **3A**]
Utilization-based shared-savings	A payment arrangement that allows providers to share in a portion of any savings they generate due to meeting quality and utilization targets that produce savings (e.g., Medicare CPC+ Track 1 program). There are no financial targets in these arrangements; instead there are utilization targets that impact a significant portion of the total cost of care. Examples of utilization measures include, but are not limited to, emergency department utilization, inpatient admissions, and readmissions. Utilization-based shared-savings provides an upside-only financial incentive for providers or provider entities to reduce unnecessary care or utilization for a defined population of patients or an episode of care, and to meet quality targets. [APM Category Framework **3A**]

Appendix B: About the CMS Alliance to Modernize Healthcare

The Centers for Medicare & Medicaid Services (CMS) as primary, along with the Department of Health & Human Services (HHS), sponsors the first health-related federally funded research and development center (Health FFRDC). The Health FFRDC is appropriate for supporting complex and critical health-related programs and initiatives of national importance. The Health FFRDC stakeholders have access to the health care expertise and research of the FFRDC for business, technical, and policy needs, in order to perform work that can't be done as effectively in-house or by commercial sources, or when the work requires special access to sensitive information.

A collaborative partnership from nonprofits, academia, and industry is dedicated to the Health FFRDC. This collaboration provides specialized expertise, health capabilities, and innovative solutions to transform delivery of the nation's health care services. Government organizations and other entities have ready access to this network of partners that also includes other leading health care organizations.

CMS, through a competitive bidding process, selected a qualified FFRDC Operator to lead the Health FFRDC, working in partnership with CMS and HHS. As a trusted, not-for-profit adviser, the Health FFRDC Operator has access, beyond what is allowed in normal contractual relationships, to government and supplier data,

including sensitive and proprietary data; and to employees, government facilities, and equipment that support health missions. The Health FFRDC Operator was selected because it is capable and fully equipped to apply a combination of large-scale enterprise systems engineering and specialized health subject matter expertise to achieve the strategic objectives of CMS, HHS, and other government organizations charged with health-related missions. The Health FFRDC Operator is uniquely qualified and experienced to objectively analyze long-term health system problems, address complex technical questions, and generate creative and cost-effective solutions in strategic areas such as quality of care, new payment models, and health care system transformation.

The current ***Health FFRDC Operator*** *is The MITRE Corporation (2012 - 2023).*

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