HCP LAN
Health Care Payment Learning & Action Network

MEASURING PROGRESS

ADOPTION OF ALTERNATIVE PAYMENT MODELS IN COMMERCIAL, MEDICARE ADVANTAGE, AND STATE MEDICAID PROGRAMS

Contents

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Formally established under Federal Acquisition Regulation (FAR) Part 35.017, FFRDCs meet special, long-term research and development needs integral to the mission of the sponsoring agency—work that existing in-house or commercial contractor resources cannot fulfill as effectively. FFRDCs operate in the public interest, free from conflicts of interest, and are managed and/or administered by not-for-profit organizations, universities, or industrial firms as separate operating units. The CAMH FFRDC applies 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. As a trusted, not-for-profit adviser, the CAMH FFRDC has access, beyond what is allowed in normal contractual relationships, to government and supplier data, including sensitive and proprietary data, and to employees and government facilities and equipment that support health missions.

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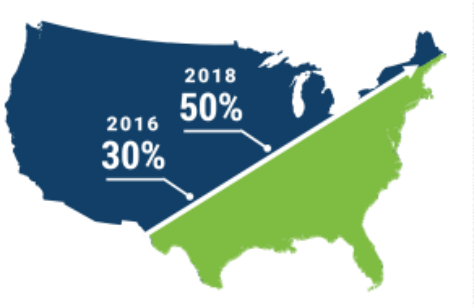
Overview

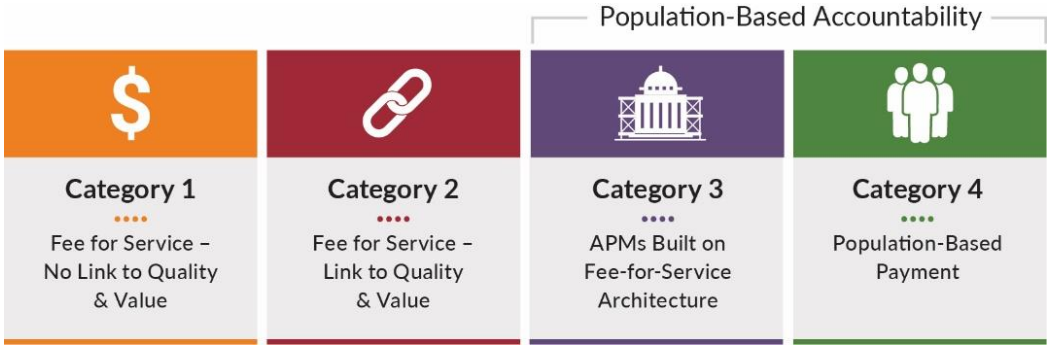
In March 2010, the passage of the Affordable Care Act revolutionized health care payment in the United States by expanding access to health insurance and establishing the Center for Medicare & Medicaid Innovation (the Innovation Center) to assess new models of care. The development and adoption of effective alternative payment models (APMs) has been a central component of this reform effort. APMs have the potential to realign treatment and payment incentives to improve care quality while reducing costs. In 2015, the U.S. Department of Health and Human Services (HHS) further endorsed this vision of better care and smarter spending by announcing a goal of tying 30% of traditional fee-for-service (FFS), Medicare payments to quality or value through alternative payment models (APMs) by 2016 and 50% by 2018. These goals are expected to accelerate the adoption and dissemination of meaningful financial incentives to reward providers delivering higher quality and higher value care.



The Health Care Payment Learning & Action Network (LAN) expanded these goals across the entire U.S. health system to encompass the public and private sectors. In March 2016, HHS announced the achievement of its first goal with an estimated 30% of Medicare FFS payments tied to APMs. To quantify the adoption of APMs across the country, the LAN embarked on a national data collection effort aimed to measure the implementation of APMs in the commercial, Medicare Advantage, and state Medicaid market segments.

Before the LAN could track the nation's progress toward its goals, however, it was critical to develop both standardized definitions and categories of APMs, and measurement methodologies that were meaningful and understandable to the targeted insurance markets. The LAN's Guiding Committee convened the Alternative Payment Model Framework and Progress Tracking Work Group ("Work Group") to bring together public and private stakeholders in order to both assess APMs in use across the nation and define terms and concepts essential for understanding, categorizing, and measuring APMs. In January 2016, the Work Group published the APM Framework White Paper, which describes the APM Framework (Figure 1) and how it was developed.

Figure 1: APM Framework At-a-Glance



With the help of technical experts, the Work Group developed a survey instrument to assess APM adoption among commercial, Medicare Advantage, Medicaid managed care health plans, and state

Medicaid programs. The questions and metrics in the survey track to the categories and subcategories of the APM Framework. The survey attempts to quantify the amount of health plan in- and out-of-network spending that flows through APMs—including key areas of pharmacy and behavioral health spending, if data are available.

Payer Collaborative Pilot

To test whether the survey instrument could adequately measure APM adoption according to the APM Framework, the Work Group pilot tested the survey with the participants of a LAN Payer Collaborative established for this purpose. The Payer Collaborative was composed of Medicaid and private health plans of varying sizes, with differing market segments and geographic representation. Participants in the Payer Collaborative understood the goal of the survey and key design decisions made by the Work Group, and nine health plans volunteered to test the survey instrument. In mid-February, the Payer Collaborative launched a five-week pilot test to determine how feasible it was for health plans to provide the data requested of them and also understand the time and resources which health plans required in order to provide the data. The pilot allowed the LAN to refine the methodology and to develop precise definitions for measurement before launching the national APM measurement effort.

Data Source

The Work Group determined that health plans were the optimal source of data for tracking the implementation of APMs. Health plans pay providers for delivering health care services to patients, and the contracts between plans and providers establish whether plans pay providers through traditional FFS or alternative payment models.

To advance our understanding of the depth and breadth of payment innovation, the LAN invited health plans to join HHS and the LAN in this critical APM measurement effort. The LAN capitalized on existing networks and forged new partnerships in order to increase awareness and engage health plans. In addition to partnering with America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA), which is further discussed below, the LAN collaborated with several other associations to invite their respective members to directly participate in this effort, and/or 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 and promote the measurement effort among broader audiences and those health plans with existing ties to the LAN.

Health plans had multiple paths to participate in the national APM measurement effort. In addition to the LAN's effort, two national health plan associations—AHIP and BCBSA—fielded surveys to their health plan members and structured their queries according to the APM Framework. All three avenues of data collection requested that health plans report the total dollars paid to providers through Categories 1, 2, and a composite of Categories 3 and 4, which in this measurement effort serve as aggregated numerators that will be divided by the aggregated denominator of total in- and out-of-network health care spending reported by the health plans. Health plans submitting data directly to the LAN were also given the option to report dollars paid at the more granular level of the various payment model subcategories in the APM Framework and by market segment (e.g., commercial, Medicare Advantage, and Medicaid).

Across the three pathways of data collection, 70 health plans participated, as well as two Medicaid FFS states, representing approximately 19,900,300 of the nation's covered lives, and 67% of the national market (excluding traditional Medicare). This percentage is based on a denominator of approximately 297,330,000 covered lives across all three market segments. This denominator comprises the Kaiser Family Foundation's estimate of approximately 16,800,000 beneficiaries covered by Medicare Advantage[1], approximately 72,530,000 beneficiaries in Medicaid and CHIP[2], and the U.S. Census Bureau's estimate of 208,000,000 lives covered by private insurers (commercial market)[3].

Scope

While the LAN APM measurement effort encompassed commercial, Medicare Advantage, Medicaid Managed Care, and FFS Medicaid states' information to quantify total health care spending across the APM categories, certain items were not included in the scope of the study. Specifically, the national APM measurement effort did not include or address the following:

Traditional (Non-Medicare Advantage) Medicare: The Centers for Medicare & Medicaid Services (CMS) had already begun regularly tracking the implementation of APMs in traditional Medicare before the formation of the LAN, and it continues to do so in alignment with the APM Framework. As a result, the LAN effort does not currently gather data about traditional Medicare. However, there is interest by CMS and the Work Group to incorporate traditional Medicare data with the LAN data in the future.

Reporting Only the Incentive Portion: The Work Group had significant interest in measuring the intensity and amount of the financial incentives of APMs for providers. However, according to health plans, this information is very difficult to collect, as payments are often made a 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. The Work Group is interested in collecting information about the incentives in future efforts.

How Payments Affect Providers Downstream: The Work Group was also interested in 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 physicians.

Certain Medicaid Services: This APM measurement effort does not include health care spending for Medicaid long-term care services or dual-eligible beneficiaries. Long-term care plans provide unique services and may be included in future APM measurement efforts. Dual-eligible plans were excluded due to the difficulty of separating the streams of payment from Medicare and Medicaid and the potential for double counting.

Data Collection, Surveys, and Process

The national APM measurement effort combines data from the LAN survey, the BCBSA survey, and AHIP's survey. All three surveys asked health plans to report the total dollars paid to providers through

[1] http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/

[2] http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/

[3] http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf. Table 1.

APM Framework Categories 1, 2, and a composite of Categories 3 and 4, the numerators that will be divided by the total in- and out-of-network health care spend reported by health plans, the denominator. The LAN aggregated the data across the three surveys to produce the final results.

The LAN Survey

The LAN data collection period started on May 19 and ran through July 13, 2016. For this effort, the LAN created two sets of metrics[4] that would determine the extent of APMs: 2015 "look-back" metrics and 2016 "point-in-time" metrics. The 2015 look-back metrics asked plans to report dollars paid in either the previous calendar year or most recent 12 months for which the plan had data in order to show the percent of actual payments made through APMs. The 2016 point-in-time metrics asked plans to estimate the dollars that would be paid to providers in 2016 based on contracts in place as of January 1, 2016, in order to align with traditional Medicare's methodology.

Because most payment innovations typically incorporate multiple payment methods (e.g., FFS plus a care coordination fee and shared savings), plans were asked to report dollars paid according to the most dominant or advanced payment method they used (e.g., shared savings).

Health plans participating through the LAN were offered the opportunity to execute a data sharing agreement with the MITRE Corporation[5] which required all individual plan data to be kept strictly confidential. In order to maintain impartiality and confidentiality, the MITRE Corporation received, analyzed, and aggregated all individual plan data, not HHS.

The LAN reviewed health plan responses in order to identify outlier or inconsistent data, and provided follow-up questions to plans to support data integrity. Health plans either clarified or modified their responses as appropriate.

2015 Look-Back Metrics

The method for calculating the 2015 look-back metrics required health plans to retrospectively examine the actual payments they made to providers through the different APMs and categorize them accordingly. For the APMs in Categories 3 and 4 that hold providers accountable for their patients' total cost of care, health plans could report dollars paid based on members attributed to the method.

[4] For additional information on the process for developing the APM Framework, the categories, and subcategories, which serve as the foundation of the metrics, please see the APM White Paper.

[5] The MITRE Corporation, as the operator of the CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research and Development Center (FFRDC), convened and is independently managing the LAN.

Table 1: 2015 Look-Back Metrics

#	Numerator	Denominator	Metric
1	N/A	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Denominator to inform the metrics below.
	Alternative Payment Model Framework – Category 1 (Metrics are NOT linked to quality)		
2	Total dollars paid to providers through **legacy payments (including FFS without a quality component and diagnosis-related groups (DRGs))** in calendar year (CY) 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Dollars under legacy payments (including FFS without a quality component, DRGs, and capitation without quality): Percent of total dollars paid through legacy payments (including FFS without a quality component and DRGs) in CY 2015 or most recent 12 months.
	Alternative Payment Model Framework – Category 2 (All methods below are linked to quality)		
3	Dollars paid for **foundational spending to improve care (linked to quality)** in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Foundational spending to improve care: Percent of dollars paid for foundational spending to improve care in CY 2015 or most recent 12 months.
4	Total dollars paid to providers through **FFS plus P4P payments** (linked to quality) in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Dollars in P4P programs: Percent of total dollars paid through FFS plus P4P (linked to quality) payments in CY 2015 or most recent 12 months.

#	Numerator	Denominator	Metric
5	Total dollars paid in Category 2 in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Payment Reform - APMs built on FFS linked to quality: Percent of total dollars paid in Category 2.
	Alternative Payment Model Framework – Category 3 (All methods below are linked to quality)		
6	Total dollars paid to providers through **FFS-based shared-savings** (linked to quality) payments in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments in CY 2015 or most recent 12 months.
7	Total dollars paid to providers through **FFS-based shared-risk** (linked to quality) payments in CY 2015 or most recent 12 months	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Dollars in shared-risk (linked to quality) programs: Percent of total dollars paid through FFS-based shared-risk payments in CY 2015 or most recent 12 months.
8	Total dollars paid to providers through **procedure-based bundled/episode payments** (linked to quality) programs in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments in CY 2015 or most recent 12 months.
9	Total dollars paid to providers through **population-based payments that are not condition-specific (linked to quality)** in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Population-based payments to providers that are not condition-specific (linked to quality): Percent of total dollars paid through population-based (linked to quality) payments that are not condition-specific in CY 2015 or most recent 12 months.

#	Numerator	Denominator	Metric
10	Total dollars paid in Category 3 in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.
	Alternative Payment Model Framework – Category 4 (All methods below are linked to quality)		
11	Total dollars paid to providers through **population-based payments for conditions (linked to quality)** in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments linked to quality in CY 2015 or most recent 12 months.
12	Total dollars paid to providers through **condition-specific, bundled/episode payments (linked to quality)** in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Dollars in condition-specific bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode-based payments linked to quality in CY 2015 or most recent 12 months.
13	Total dollars paid to providers through **full or percent of premium population-based payments (linked to quality)** in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	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 2015 or most recent 12 months.
14	Total dollars paid in Category 4 in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.

#	Numerator	Denominator	Metric
	Aggregated Metrics (Comparison between Categories 1, 2-4, and 3 & 4)		
15	Total dollars paid to providers through **legacy payments (including FFS without a quality component and DRGs)** payments in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Legacy payments not linked to quality: Percent of total dollars paid based through legacy payments (including FFS without a quality component, DRGs, and capitation without quality).
16	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Payment Reform Penetration - Dollars in Categories 2-4: Percent of total dollars paid through payment reforms in Categories 2-4 in CY 2015 or most recent 12 months.
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2015 or most recent 12 months.	Total dollars paid to providers (in and out of network) for members in CY 2015 or most recent 12 months.	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through payment reforms in Categories 3 and 4 in CY 2015 or most recent 12 months.

2016 Point-in-Time Metrics

Forty health plans of varying sizes and from different geographies, and two states, responded to the 2016 point-in-time metrics. Of the 40 health plans and two states, 26 health plans representing 91,258,914 lives and 43.75% of the commercial market reported the commercial 2016 point-in-time metrics; 23 health plans representing 9,663,002 lives and 57.52% of the Medicare Advantage market reported the Medicare Advantage 2016 point-in-time metrics; and 28 health plans and two states representing 28,005,251 lives and 38.61% of the Medicaid market reported the Medicaid 2016 point-in-time metrics.[6]

The 2016 point-in-time metrics capture expected payments in 2016 based on contracts executed by the health plan (or state) and provider partners by January 1, 2016. The LAN APM measurement effort allowed for two methods of calculating these metrics:

[6] Note that most plans reported data in more than one market segment.

- Option 1: The number of members attributed to [APM] based on contracts in place on 1/1/16 multiplied by the average cost per member per year divided by the total spend as of 1/1/16.
- Option 2: The most recent dollars paid through [APM] divided by the most recent total spend in a 12-month period before 1/1/16.

If the health plan used Option 1 to calculate the 2016 point-in-time metrics, the plan had to adjust for possible double counting of members, and therefore, dollars paid through multiple APMs. To adjust for double counting, the health plan was instructed to remove members attributed to the total cost of care APMs from the APMs that do not hold providers accountable for the total cost of care. A health plan did not need to adjust for double counting if it used *Option 2* to calculate the metrics.

Table 2: 2016 Point-in-Time Metrics

#	Numerator	Denominator	Metric
1	N/A	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Denominator to inform the metrics below.
	APM Framework – Category 3 (APMs Built on a Fee-for-Service Architecture)		
2	Total dollars paid through **FFS-based shared-savings (linked to quality)** payments based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Dollars in shared-savings (linked to quality) programs: Percent of total dollars paid through FFS-based shared-savings payments based on contracts in place on 1/1/16.
3	Total dollars paid through **FFS-based shared-risk (linked to quality)** payments based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Dollars in shared-risk programs: Percent of total dollars paid through FFS-based shared-risk (linked to quality) payments based on contracts in place on 1/1/16.
4	Total dollars paid through **procedure-based bundled/episode payments (linked to quality)** programs based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Dollars in procedure-based bundled/episode payments (linked to quality) programs: Percent of total dollars paid through procedure-based bundled/episode payments based on contracts in place on 1/1/16.

#	Numerator	Denominator	Metric
5	Total dollars paid through **population-based payments that are not condition-specific (linked to quality)** based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Population-based payments to providers that are not condition-specific and linked to quality: Percent of total dollars paid through population-based (linked to quality) payments not condition specific based on contracts in place on 1/1/16.
6	Total dollars paid in Category 3 based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Payment Reform - APMs built on FFS architecture: Percent of total dollars paid in Category 3.
	APM Framework – Category 4 (Population-Based Payments that are Condition-Specific or Comprehensive)		
7	Total dollars paid through **population-based payments for conditions (linked to quality)** based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Population-based payments for conditions (linked to quality): Percent of total dollars paid through condition-specific population-based payments (linked to quality) based on contracts in place on 1/1/16.
8	Total dollars paid through **condition-specific, bundled/episode payments (linked to quality)** based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Dollars in condition-specific bundled/episode payment programs (linked to quality): Percent of total dollars paid through condition-specific bundled/episode-based payments linked to quality based on contracts in place on 1/1/16.
9	Total dollars paid through **full or percent of premium population-based payments (linked to quality)** based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	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 based on contracts in place on 1/1/16.

#	Numerator	Denominator	Metric
10	Total dollars paid in Category 4 based on contracts in place on 1/1/16.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Payment Reform - Population-based APMs: Percent of total dollars paid in Category 4.
	Aggregated Metrics (Category 3 & 4)		
11	Total dollars paid through APMs in Categories 3 and 4 based on contracts in place on January 1, 2016.	Total dollars paid to providers (in and out of network) for members based on contracts in place on 1/1/16.	Payment Reform Penetration - Dollars in Categories 3 and 4: Percent of total dollars paid through APMs in Categories 3 and 4 based on contracts in place 1/1/16.

The BCBSA Survey

The Blue Cross Blue Shield Association (BCBSA) reported the data elements listed below to the LAN for the purposes of measuring multi-payer adoption of APMs nationally. BCBSA collaborated with the LAN and America's Health Insurance Plans (AHIP) to assure alignment of survey questions to facilitate data aggregation.

To collect these data, BCBSA included questions that were aligned with the LAN and AHIP in an annual survey of member plans addressing the delivery of value-based health care. The data elements listed below were submitted to, validated by, and aggregated by BCBSA in the third quarter of 2016. Data elements that were reported to the LAN include:

- The number of participating plans
- The total number of covered lives by participating plans
- APM Category 1: total dollars
- APM Category 2: total dollars
- APM Categories 3 and 4: total dollars
- Aggregated total dollars in all Categories

Data were collected for health care spend paid to all providers for dates of service in calendar year 2015 (1/1/2015 - 12/31/2015).

The AHIP Survey

AHIP worked in collaboration with BSBCA and the LAN in developing a subset of the questions in AHIP's annual survey. Questions focused on the dollars associated with APMs as defined using the LAN APM framework. Using a key informant approach, AHIP emailed invitations to chief medical officers and payment innovation staff from their member plans, who then shared the survey with their teams as appropriate. Responses were based on one of two time periods: 1) "as of March 31, 2016", or 2) "for all dates of service in calendar year 2015." Data were collected using a web-based survey instrument generated through Qualtrics software (Qualtrics, Provo, UT). After responses were received, AHIP contacted health plans with follow up questions for clarifications and any updates to the data as

appropriate. Some of AHIP member plans responded to the survey while also sharing data with the LAN or BCBSA. AHIP worked with the LAN and BCBSA to ensure that aggregated data shared with the LAN included information from plans that only responded to AHIP to avoid double-counting.

Merging the Three Surveys

The LAN merged several data elements from the BCBSA and AHIP surveys with those gathered directly by the LAN. The data elements include the total number of health plans participating, the total number of lives covered by participating plans, the aggregated total dollars in Category 1 (numerator), the aggregated total dollars in Category 2 (numerator), the aggregated total dollars in a composite of Categories 3 and 4 (numerator), and the aggregated total dollars in all categories (denominator).

To avoid double counting, the LAN provided a list of health plans participating in its APM measurement effort to each health plan association. The associations agreed not to share the LAN list with member health plans and others. The associations then compared the list of health plans participating in the LAN survey to the list of plans participating in their own survey to identify the plans that participated in more than one survey and remove those with any overlap. In the case of duplicates, the LAN and trade associations worked together to determine the best way to extract duplicate data so that each health plan's data were counted only once.

Results

For the 2015 look-back metrics, the combined LAN, BCBSA, and AHIP data show the following:

- 62% of health care dollars in Category 1
- 15% of health care dollars in Category 2
- 23% of health care dollars in a composite of Categories 3 and 4

For the 2016 point-in-time metrics, the LAN data[7] show the following:

- 25% of health care dollars in a composite of Categories 3 and 4
    - 22% of commercial health care dollars in a composite of Categories 3 and 4
    - 41% of Medicare Advantage health care dollars in a composite of Categories 3 and 4
    - 18% of Medicaid health care dollars in a composite of Categories 3 and 4

Limitations

Health Plan Participation is Voluntary: While the LAN data, combined with the BCBSA and AHIP data, represent 67% of the covered lives in the U.S., the effort did not have full participation from all health plans in the U.S. Furthermore, health plan participation in any of the three survey avenues was voluntary. As a result, the findings may be biased by self-selection; health plans actively pursuing payment reform may have been more likely to respond to the surveys, potentially driving results in Categories 2-4 upward. Additionally, the voluntary nature of the effort did not allow a comparably representative view of covered lives in the three separate market segments.

[7] The 2016 point-in-time results only reflect health plan and state responses that were submitted to the LAN, which represent 67% of the market and are not nationally representative. The BCBSA and AHIP surveys did not include the point-in-time metric.

Multiple Data Collection Surveys: To both address the administrative burden on some health plans and maximize health plan participation, three entities fielded surveys—the LAN, BCBSA, and AHIP. All surveys were based on the LAN APM Framework, but there were some differences. In particular, both the BCBSA and AHIP surveys (2015 results) requested health plans report provider payment data at the APM Framework Category level (i.e., Categories 1, 2, and a composite of 3 and 4), while the LAN survey asked health plans to report payments made through specific APMs at the subcategory level. In addition, both association surveys (2015 results) asked health plans to report data that combines information about APM adoption across all of their lines of business, while the LAN survey asked health plans to report data separately for their commercial, Medicare Advantage, and Medicaid business.

Inability to Report Subcategory Payment Methods: Given that not all surveys collected data at the subcategory level, results from all three surveys, for both 2015 and 2016 metrics, can only be combined at the category level.

Inability to Report by Market Segment: Given that not all surveys collected data separately for each line of business or market segment (commercial, Medicare Advantage, and Medicaid), the combined 2015 results of the three surveys cannot be reported by market segment. Though the LAN collected data at the market segment level, these data alone are not representative of each overall market.

Potential Variation in the Interpretation of the 2015 and 2016 Metrics: The LAN worked to facilitate a consistent interpretation by health plans of the APM categories, subcategories, terms, and the methods for reporting through precise definitions, training sessions, written instructions, and discussions with individual health plans seeking clarification. However, the interpretation of the metrics could still create variability across individual health plans.

Health Plan Data System Challenges: Some health plans reported data system challenges with reporting payment dollars according to the APM Framework's specific categories and subcategories—for many, it was a manual process to develop new system queries and sort data according to the APM categories and subcategories. Such data system limitations can also result in health plans reporting data from different periods of time.

Appendix: Definitions

The following terms and definitions were developed to provide consistent guidance to 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. For more information and details about the proposed MACRA definition, please reference the statute and related regulations. APM Framework White Paper MACRA website
Attribution	A methodology that uses patient attestation and claims/encounter data to assign a patient population to a provider group/delivery system to manage the population's health, with calculated health care costs/savings or quality of care scores for that population. For some products, an individual consumer may select a network of physicians at the point of enrollment in a health plan (e.g., HMO). The APM Framework is agnostic to the attribution method (e.g., prospective or concurrent).
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. DRGs that are not linked to quality are in Category 1.
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.

Terms	Definitions
Category 3	 APMs built on FFS 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 performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. Providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.
Category 4	 Population-based payments. These payments are structured in a manner that encourages providers to deliver well-coordinated, high quality person-level care within a defined or overall budget. This holds 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, among other items. These payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care.
Commercial market segment	For the purposes of this APM measurement effort, 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 Employees Health Benefits (FEHB) Program, this business should be considered commercial and included in the survey data.
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**].

Terms	Definitions
CY 2015 or most recent 12 months	Calendar year 2015 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." This is not an annualized (point-in-time) reporting.
Diagnosis-related groups (DRGs)	A clinical category risk adjustment system that uses information about patient diagnoses and selected procedures to identify patients that 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.
Double count adjustment (discounting or reductions for double counting)	When providing a point-in-time January 1, 2016 payment, it is important to adjust for possible double counting of members attributed to multiple APMs. For example, it is possible that a member affiliated with a shared savings accountable care organization (ACO) is also affiliated with a bundled payment program. The reporting health plan either has to create a hierarchy where the situation for double counting members is eliminated or greatly reduced, or identify the prominent APM and adjust other programs for any overlap in members. For example, if a shared savings ACO is the most prominent model for the health plan, the health plan would discount the percentage of total dollars paid through shared savings (numerator/denominator) from the total dollars paid through bundled payment. If the percentage of total dollars paid through shared savings is 20% and the total dollars paid through bundled payment is $500 million, one would multiply 500 million x (1-0.20) = $400 million.
Fee-for-service	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, care coordination/management, after-hour availability, patient communication enhancements, or 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**].

Terms	Definitions
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**].
As of January 1, 2016	A "point in time" in which health plans will report data. The metric will account for the contracts in place on that date and estimate the number of members attributed to those contracts. The contracts referenced for this metric must already be "inked" on 1/1/16. This metric does not reflect potential contracts that might be expected in CY 2016, nor does it adjust for possible growth or attrition of members, contracts, or dollars.
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 FFS, DRGs and per diems [APM Framework Category **1**].
Linked to quality	Payments that are set or adjusted based on evidence that providers meet quality standards or improve care or clinical services, including providers who report quality data, or providers who meet the 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."
Medicaid market segment	For the purposes of this APM measurement effort, 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 should exclude the following: health care spending for dual-eligible beneficiaries and health care spending for long-term care.
Medicare Advantage market segment	For the purposes of this APM measurement effort, 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 should include this information in its response.

Terms	Definitions
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 FFS 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** & **2D**].
Population-based payment for conditions	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**].
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 the payment covers are predefined and could be, for example, primary care services or professional services that are not specific to any particular condition [APM Framework Category **3B**].
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 **3A** & **3B**].
Provider	For the purposes of this 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.
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.

Terms	Definitions
Shared savings	A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending. 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.
Total dollars	The total estimated in- and out-of-network health care spending (e.g., annual payment amount) made to providers in CY 2015 or the most recent 12 months for which data are available.