APM Adoption Across Markets:
A Closer Look at the LAN Measurement Effort
Welcome

Andréa Caballero, MPA
Technical Project Lead
LAN APM Measurement Effort
Program Director
Catalyst for Payment Reform
Panelists

Arrah Tabebiward
Deputy Director
Center for Medicare & Medicaid Innovation

Kat Latet
Director of Health System Innovations
Community Health Plan of Washington (CHPW)

Brent Stice
Associate Vice President, Value-Based Program Operations & Analytics
Humana

John Pilotte
Director of Performance-Based Payment Policy Group
CMS

Terri Bauer
Executive Director and Head of Actuarial & Underwriting
Aetna Accountable Care Solutions
LAN APM Measurement: Success Through Partnership

- Trade Associations
- CMS
- LAN EFFORT
- Health Plans
- States
Methodology

Look back on 2018 data

<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEE FOR SERVICE – NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE – LINK TO QUALITY &amp; VALUE</td>
<td>APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION – BASED PAYMENT</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
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<tr>
<td>Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for HIT investments)</td>
<td>APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
<td>Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
<td></td>
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<tr>
<td>B</td>
<td>B</td>
<td>B</td>
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<tr>
<td>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</td>
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<tr>
<td>C</td>
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<tr>
<td>Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td></td>
<td>Integrated Finance &amp; Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</td>
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<tr>
<td>3N</td>
<td>3N</td>
<td>4N</td>
<td></td>
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<tr>
<td>Risk Based Payments NOT Linked to Quality</td>
<td></td>
<td>Capitated Payments NOT Linked to Quality</td>
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</table>
Methodology (cont.)

Commercial, Medicaid Managed Care Organizations and Medicare Advantage health plans, state Medicaid agencies, and Traditional Medicare contributed to the data set.
Limitations

• Health plan/payer participation was voluntary
• Potential variation in the interpretation of the metrics
• Data system challenges
### HCP-LAN New Goal Statement

**Goal Statement**

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of shared accountability alternative payment models.

<table>
<thead>
<tr>
<th>Year</th>
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<td>100%</td>
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</table>
Aggregate Results at a Glance

**Category 1: Fee-for-Service - No Link to Quality & Value**
- 39.1%

**Category 2: Fee-for-Service - Link to Quality & Value**
- A: Foundational Payments for Infrastructure & Operations
- B: Pay for Reporting
- C: Pay-for-Performance
- 25.1%

**AGGREGATED DATA**
- 39.1%
- 30.7%
- 25.1%
- 5.1%

**Category 3: APMS Built on Fee-for-Service Architecture**
- A: Upside Rewards for Appropriate Care
- B: Upside & Downside for Appropriate Care
- 21.3%
- 9.4%

**Category 4: Population-Based Payment**
- A: Condition-Specific Population-Based Payment
- B: Comprehensive Population-Based Payment
- C: Integrated Finance & Delivery Systems
- 1.8%
- 2.9%
- 0.4%

14.5% Combination of Categories 3B, 4A, 4B, & 4C Represents Shared Accountability APMS

Based on 62 plans, 7 states, Traditional Medicare

OCTOBER 24, 2019 CAPITOL HILL HYATT REGENCY HOTEL WASHINGTON, DC
Line of Business Results – Commercial

**CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE**
- 55.7%

**CATEGORY 2: FEE-FOR-SERVICE - LINK TO QUALITY & VALUE**
- 0.2% Foundational Payments for Infrastructure & Operations
- 0.1% Pay-for-Reporting
- 13.9% Pay-for-Performance

**CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**
- 19.5% Upside Rewards for Appropriate Care
- 8.1% Upside & Downside for Appropriate Care

**CATEGORY 4: POPULATION-BASED PAYMENT**
- 10.6% Combination of Categories 3B, 4A, 4B, & 4C Represents Shared Accountability APMs.
- 0.7% Condition-Specific Population-Based Payment
- 1.4% Comprehensive Population-Based Payment
- 0.4% Integrated Finance & Delivery Systems

Representativeness of covered lives: Commercial - 61%
Line of Business Results – Medicare Advantage

**Category 1: Fee-for-Service - No Link to Quality & Value**
- 39.5%

**Category 2: Fee-for-Service - Link to Quality & Value**
- <0.1% Foundational Payments for Infrastructure & Operations
- <0.1% Pay-for-Reporting
- 6.9% Pay-for-Performance

**Category 3: APMS Built on Fee-for-Service Architecture**
- 29.3% Upside Rewards for Appropriate Care
- 7.1% Upside & Downside for Appropriate Care

**Category 4: Population-Based Payment**
- 1.4% Condition-Specific Population-Based Payment
- 14.0% Comprehensive Population-Based Payment
- 1.8% Integrated Finance & Delivery Systems

Representativeness of covered lives: Medicare Advantage - 67%

Combination of Categories 3B, 4A, 4B, & 4C Represents Shared Accountability APMs.
Line of Business Results – Traditional Medicare

**CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE**
- 10.2%

**CATEGORY 2: FEE-FOR-SERVICE - LINK TO QUALITY & VALUE**
- 48.9%

**CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**
- Upside Rewards for Appropriate Care: 22.7%
- Upside & Downside for Appropriate Care: 13.8%

**CATEGORY 4: POPULATION-BASED PAYMENT**
- Condition-Specific Population-Based Payment: 3.4%
- Comprehensive Population-Based Payment: 1.0%
- Integrated Finance & Delivery Systems: 0%

*Representativeness of covered lives: Traditional Medicare - 100%*

*Combination of Categories 3B, 4A, 4B, & 4C Represents Shared Accountability APMs.*
Line of Business Results - Medicaid

**CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE**
- 66.1%

**CATEGORY 2: FEE-FOR-SERVICE - LINK TO QUALITY & VALUE**
- 1.1% Foundational Payments for Infrastructure & Operations
- <0.1% Pay-for-Reporting
- 9.5% Pay-for-Performance

**CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE**
- 15.0% Upside Rewards for Appropriate Care
- 2.4% Upside & Downside for Appropriate Care

**CATEGORY 4: POPULATION-BASED PAYMENT**
- 1.9% Condition-Specific Population-Based Payment
- 3.9% Comprehensive Population-Based Payment
- 0.1% Integrated Finance & Delivery Systems
Informational Questions

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

- **91%** think APM activity will increase
- **7%** think APM activity will stay the same
- **0%** think APM activity will decrease
- **2%** not sure or didn't answer

**Categories Payers Feel Will Increase the Most**

- **3B**: 45%
- **3A**: 31%

**Will APM adoption result in...**

- **Better quality of care?**
  - Strongly Agree/Agree: 97%
  - Strongly Disagree/Disagree: 2%
  - Unsure: 1%

- **More affordable care?**
  - Strongly Agree/Agree: 88%
  - Strongly Disagree/Disagree: 4%
  - Unsure: 8%

- **Improved care coordination?**
  - Strongly Agree/Agree: 95%
  - Strongly Disagree/Disagree: 2%
  - Unsure: 3%

- **More consolidation among health care providers?**
  - Strongly Agree/Agree: 56%
  - Strongly Disagree/Disagree: 19%
  - Unsure: 25%

- **Higher unit prices for discrete services?**
  - Strongly Agree/Agree: 9%
  - Strongly Disagree/Disagree: 63%
  - Unsure: 28%

**Top 3 Barriers:**

1. Provider willingness to take on financial risk
2. Provider ability to operationalize
3. Provider interest/readiness

**Top 3 Facilitators:**

1. Health plan interest/readiness
2. Government influence
3. Provider interest/readiness
Downside Risk Work Group and Pilot
Work Group Participation and Timeline

- **APR/MAY**: Secure Participation
- **MAY-AUG**: Convene Work Group (5 meetings)
- **SEPT**: Conduct Pilot
- **SEPT/OCT**: Review Results and Analyze Feedback
- **OCT 24**: LAN Summit

16 organizations, including CMMI, payers, state Medicaid agencies, and health plan trade associations

5 payers, 1 state Medicaid agency, CMMI
What is the LAN Trying To Measure?

We know APM Categories 3B, 4A, 4B, 4C include some two-sided risk, but not how much....

Ultimately, the LAN is interested in learning....

How much spend flows through two-sided risk contracts that contain more/less than Nominal Risk?
Key Decisions that Informed Design of Metric

- Borrow certain definitions and risk parameters from QPP
- Align nominal risk requirements with QPP
  - 3% (Total Cost of Care Contracts)
  - 8% (Percent Revenue Contracts)
- Include any type of recoupment method in determining nominal risk
- Calculate net risk by contract and report by line of business
Determining Whether a Two-sided Risk Contract Meets a Nominal Risk Risk Threshold

Risk Min \(\leq 4\%\)
Risk Share \(\geq 30\%\)

Contract Scope

TCOC (Benchmark-based) contract

Net Risk \(\geq 3\%?\)

\% Revenue Contract

Net Risk \(\geq 8\%?\)

Meets Threshold

Does NOT meet Threshold
Pilot Purpose

The LAN wanted to know...

1. Does the metric work?
2. What areas need refinement? More instructions, definitions, etc.?
3. Is the data easy to find and report?
4. Is the analysis useful for internal or external reporting?
5. What is the reporting burden to collect the data?
## Pilot Findings

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<th><strong>What did we want to learn?</strong></th>
<th><strong>What did we find?</strong></th>
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<td>Does the metric work?</td>
<td>YES, for 3B. More discussion needed on the applicability to Categories 4A, 4B, 4C.</td>
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<td>What areas need refinement? More instructions, definitions, etc.?</td>
<td>Instructions needed to address N/A for certain data elements. Worksheet and online survey were user-friendly.</td>
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<td>Is the data easy to find and report?</td>
<td>YES. Confirmed health plans use various contractual methods to recoup potential financial deficits.</td>
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<td>Is the analysis useful for internal or external reporting?</td>
<td>Moderately useful.</td>
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<td>What is the reporting burden to collect the data?</td>
<td>Multiple departments involved to collect the data. Hours to complete varied; Average 14.8 hours.</td>
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Visit the LAN Website for our Resources

https://hcp-lan.org/

**What is the Health Care Payment Learning & Action Network?**

The Health Care Payment Learning & Action Network (HCPLAN, or LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care systems’ adoption of alternative payment models (APMs). The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Since 2015, health care stakeholders have relied on the LAN to align them around core APM design components, host forums and summits to share information and inspire action, build consensus among leaders, and measure the progress of APM adoption. The LAN will continue to be a trusted partner that connects the public and private sectors, identifies and shares best practices, and guides the field in rapidly moving to value-based payment.

### OUR GOAL STATEMENT

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Exit Survey

We want to know what you think!

Let us know your thoughts at the end of each session! The Guidebook app provides quick, simple evaluations for your feedback.

Session Evaluation Survey (or scan QR code)
LAN Summit Overall Survey
Contact Us
We want to hear from you!

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Thank You!