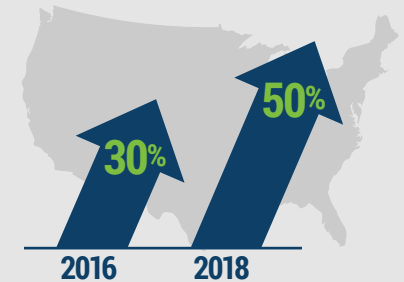


APM MEASUREMENT EFFORT

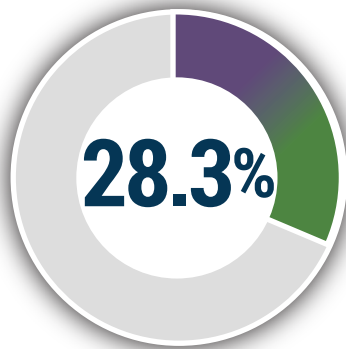
Public and private health plans, managed Medicaid FFS states, and Medicare FFS voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.



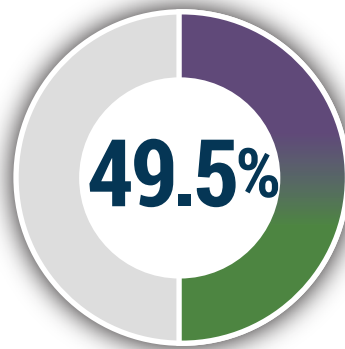
In **2017**,

34% of U.S. health care payments, representing approximately **226.3 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

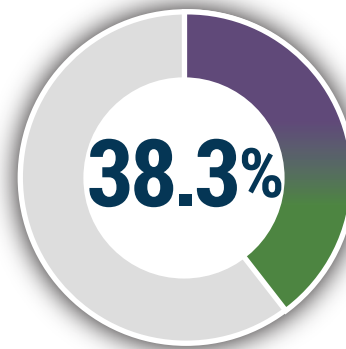
In each market, Categories 3&4 payments accounted for:



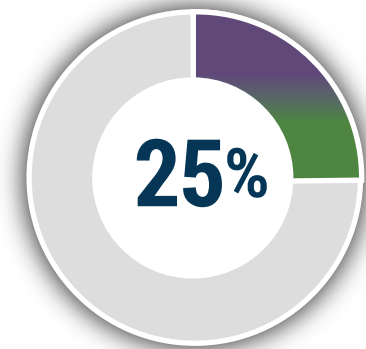
COMMERCIAL



MEDICARE
ADVANTAGE



MEDICARE
FFS



MEDICAID

Representativeness of covered lives:

Commercial - 63%
Medicare Advantage - 70%
Medicare FFS - 100%
Medicaid - 50%

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

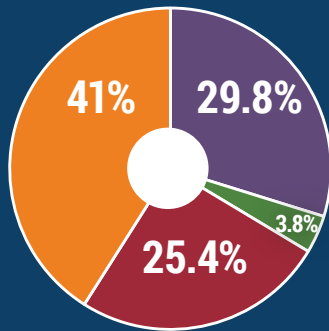
41%

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

A + **B** + **C**
 Foundational Payments for Infrastructure & Operations Pay for Reporting Pay-for-Performance

25.4%

AGGREGATED DATA



Based on 61 plans, 3 states, Medicare FFS

CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A
Upside Rewards for Appropriate Care

21.1%

B
Upside & Downside for Appropriate Care

8.7%

CATEGORY 4: POPULATION-BASED PAYMENT

A
Condition-Specific Population-Based Payment

1.5%

B
Comprehensive Population-Based Payment

2.2%

C
Integrated Finance & Delivery Systems

0.1%

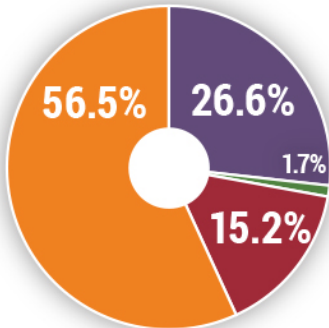
CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE

56.5%

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

A **B** **C**
 0.2% 0% 15%

COMMERCIAL



CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

18.4%

B

8.2%

CATEGORY 4: POPULATION-BASED PAYMENT

A
0.2%

B
1.4%

C
0.1%

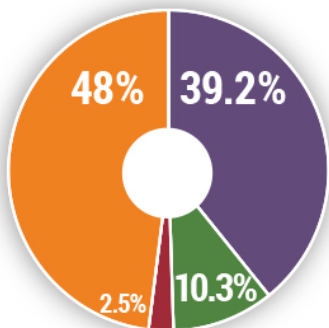
CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE

48%

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

A **B** **C**
 0% 0% 2.5%

MEDICARE ADVANTAGE



CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

25.3%

B

13.9%

CATEGORY 4: POPULATION-BASED PAYMENT

A
1.2%

B
9%

C
0.1%

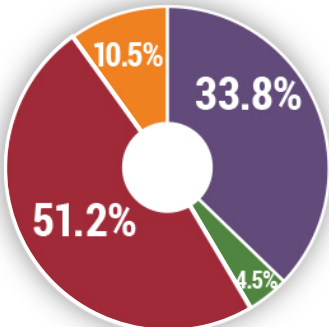
CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE

10.5%

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

51.2%

MEDICARE FFS



CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

24.6%

B

9.2%

CATEGORY 4: POPULATION-BASED PAYMENT

A
3.4%

B
1.1%

C
0%

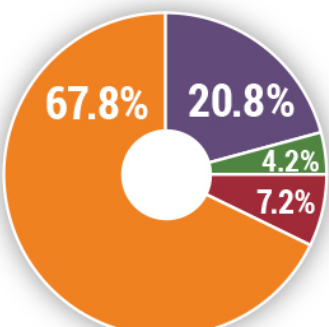
CATEGORY 1: FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE

67.8%

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

A **B** **C**
 0.1% 0.2% 6.9%

MEDICAID



CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A

17.6%

B

3.2%

CATEGORY 4: POPULATION-BASED PAYMENT

A
1.8%

B
2.2%

C
0.2%

Commercial, Medicare Advantage, and Medicaid data based on responses from 61 health plans and 3 states

CATEGORY 1: FEE-FOR-SERVICE WITH NO LINK TO QUALITY
 These are traditional FFS payments that are not adjusted to account for either infrastructure investments, provider reporting of quality data, or provider performance on cost and quality metrics. DRGs not linked to quality are also classified in Category 1.

CATEGORY 2: FEE-FOR-SERVICE LINKED TO QUALITY
 These are traditional FFS payments that are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.

CATEGORY 3: ALTERNATIVE PAYMENT MODELS (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 benchmark is established, updated, or adjusted. Providers that meet these targets are eligible to share in savings, and those that 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 in the Methodology Report.

CATEGORY 4: POPULATION-BASED PAYMENT
 These prospective payments encourage providers to deliver person-centered care within a defined scope of practice, a comprehensive collection of care, or a highly integrated finance and delivery system. These payments also 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. Category 4 APMS require accountability for appropriate care measures as a safeguard against incentives to limit necessary care.

What Do Payers Think about the Future of APM Adoption?

↑ 90%

think APM activity will increase

→ 9%

think APM activity will stay the same

↓ 0%

think APM activity will decrease

? 1%

not sure or didn't answer

Categories Payers Feel Will Be Most Impacted

3B 48%

3A 25%

Will APM adoption result in...


Strongly Agree/
Agree


Strongly Disagree/
Disagree


Unsure

...better quality of care?

99%

0%

1%

...more affordable care?

89%

2%

9%

...improved care coordination?

97%

1%

2%

...more consolidation among health care providers?

59%

18%

23%

...higher unit prices?

6%

73%

21%

 ***Top 3 Barriers:**

1. Willingness to take on financial risk
2. Ability to operationalize
3. Provider interest/readiness

 **Top 3 Facilitators:**

1. Health plan interest/readiness
2. Purchaser interest/readiness
3. TIE: Provider interest/readiness and government influence

*Please see the Methodology and Results Report and the LAN Insights Report for more information.

COMMERCIAL

Public and private health plans, managed Medicaid FFS states, and Medicare FFS voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.



COMMERCIAL



MEDICARE ADVANTAGE



MEDICARE FFS



MEDICAID

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

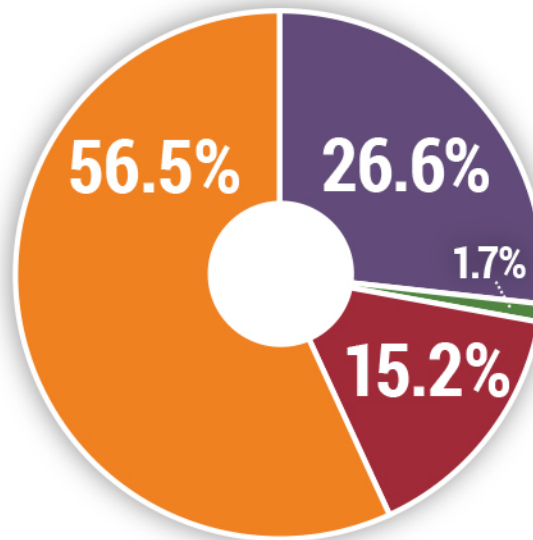
56.5%

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

0.2% Foundational Payments for Infrastructure & Operations

0% Pay for Reporting

15% Pay-for-Performance



Representativeness of covered lives:
Commercial - 63%

CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

18.4% Upside Rewards for Appropriate Care

8.2% Upside & Downside for Appropriate Care

CATEGORY 4: POPULATION-BASED PAYMENT

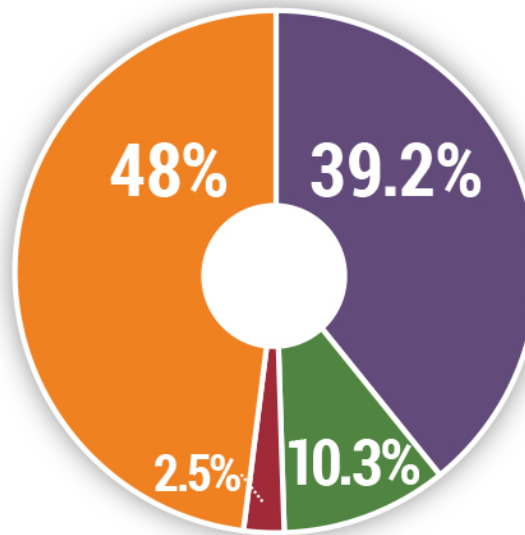
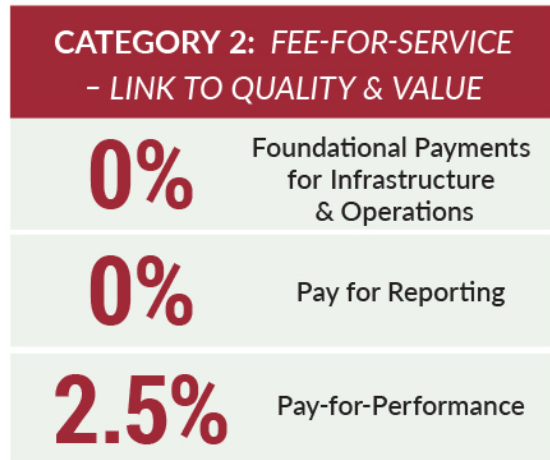
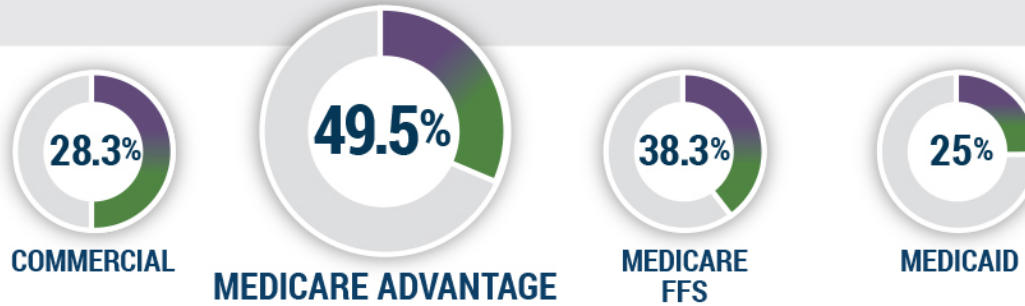
0.2% Condition-Specific Population-Based Payment

1.4% Comprehensive Population-Based Payment

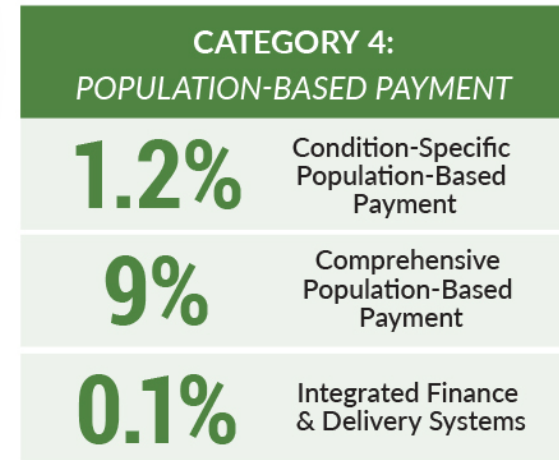
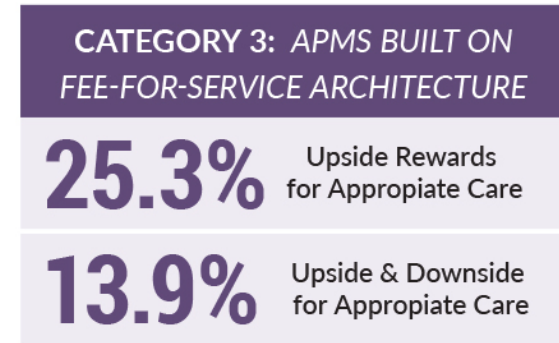
0.1% Integrated Finance & Delivery Systems

MEDICARE ADVANTAGE

Public and private health plans, managed Medicaid FFS states, and Medicare FFS voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.



Representativeness of covered lives: Medicare Advantage - 70%



MEDICARE FFS

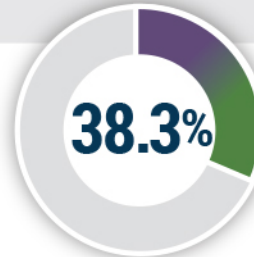
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COMMERCIAL



MEDICARE ADVANTAGE



MEDICARE FFS



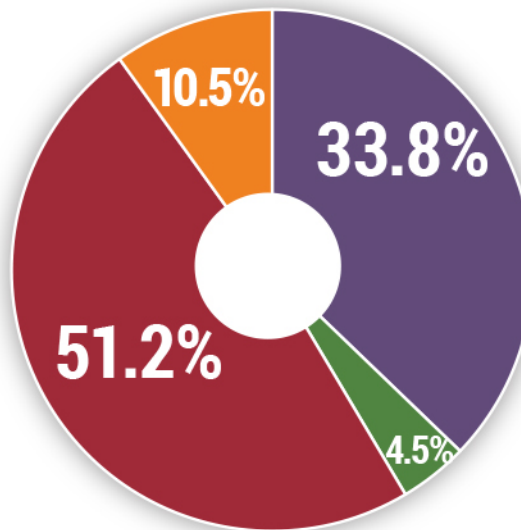
MEDICAID

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

10.5%

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

51.2%



Representativeness of covered lives:
Medicare FFS - 100%

CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

24.6% Upside Rewards for Appropriate Care

9.2% Upside & Downside for Appropriate Care

CATEGORY 4: POPULATION-BASED PAYMENT

3.4% Condition-Specific Population-Based Payment

1.1% Comprehensive Population-Based Payment

0% Integrated Finance & Delivery Systems

MEDICAID

Public and private health plans, managed Medicaid FFS states, and Medicare FFS voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.



COMMERCIAL



MEDICARE ADVANTAGE



MEDICARE FFS



MEDICAID

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

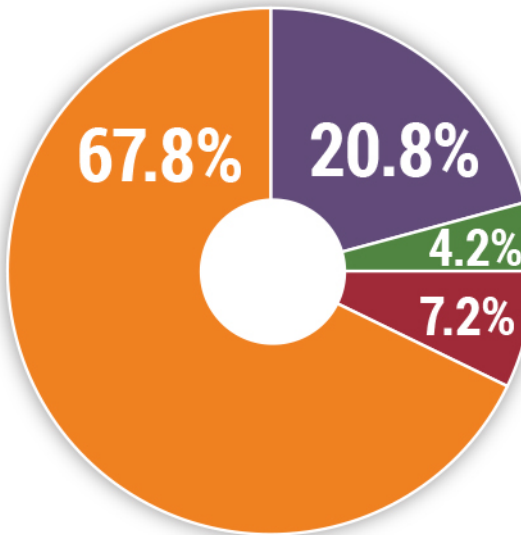
67.8%

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

0.1% Foundational Payments for Infrastructure & Operations

0.2% Pay for Reporting

6.9% Pay-for-Performance



Representativeness of covered lives: Medicaid - 50%

CATEGORY 3: APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

17.6% Upside Rewards for Appropriate Care

3.2% Upside & Downside for Appropriate Care

CATEGORY 4: POPULATION-BASED PAYMENT

1.8% Condition-Specific Population-Based Payment

2.2% Comprehensive Population-Based Payment

0.2% Integrated Finance & Delivery Systems