Application to Use Burden/Hours from Generic PRA Clearance:
Health Care Payment Learning and Action Network
(CMS-10620, OMB 0938-1297)

Generic Information Collection (GenIC):

Tracking the adoption of alternative payment models

Office of Communications (OC)
Centers for Medicare & Medicaid Services (CMS)

A. Background

Changing the way health care is paid for in the United States is a key priority for health reform. Medical treatment and services have traditionally been paid for in a fee-for-service manner, rewarding clinicians for the quantity of care they provided. Alternative payment models (APMs) are designed to reward providers for the quality, efficiency, and coordination of their care. All APMs and payment reforms that seek to deliver better care at lower cost share a common pathway for success: providers, payers, and others in the health care system must make fundamental changes in their day-to-day operations that improve quality and reduce the cost of health care. Making operational changes will be viable and attractive only if new alternative payment models and payment reforms are broadly adopted by a critical mass of payers. When providers encounter new payment strategies for one payer but not others, the incentives to change are weak. When payers align their efforts, the incentives to change are stronger and the obstacles to change are reduced. As a result, the U.S. health care system will shift from a fee-for-service predominant system to one in which most care is provided through APMs.

The Health Care Payment Learning and Action Network (LAN) has brought together private payers, providers, employers, state partners, consumer groups, individual consumers, and many others to accelerate the transition to APMs. In addition, the LAN's goals, 30% adoption of APMs by 2016 and 50% by 2018 for the entire U.S. health system, are parallel with those of the Department of Health and Human Services (HHS). In early March, HHS announced that an estimated 30% of Medicare fee-for-service payments are now tied to APMs, thus reaching the first HHS milestone almost a year ahead of schedule.

The LAN's data collection initiative will help CMS determine how well these goals for Medicare are being realized by the private sector and by state Medicaid programs. It will also enable us to identify any major differences in APM adoption among commercial, Medicaid Managed Care, and Medicare Advantage plans. The ultimate goal is a consistent and harmonized "apples-to-apples" comparison of the various payment models in use nationwide.

B. Description of Information Collection

The purpose of this information request is to collect health care spending data from commercial, Medicaid, and Medicare Advantage payers to track the health system's progress in adopting APMs. This information will help the LAN understand the progress made in shifting payments to APMs, as well as allowing the delivery system to plan for the pace of change in health care payments across public and private payers. The LAN adapted the CMS payment taxonomy and expanded it by introducing refinements that describe health care payment through the stages of transition from pure fee-for-service to APMs and, ultimately, population based payments. The resulting APM Framework classifies payment models into four categories:

- Category 1—fee-for-service with no link of payment to quality;
- Category 2—fee-for-service with a link of payment to quality;
- Category 3—alternative payment models built on fee-for-service architecture; and
- Category 4—population-based payment.

In order for this exercise to yield a meaningful representation of the private insurance market and gauge real progress towards the goal of moving 30% of the total U.S. health care spending to APMs, we are targeting major insurers that, in total, represent at least 60% for commercial,

Medicaid, and Medicare Advantage markets. As each payer varies in the size of their market share, CMS estimates we will need to approach 200 to 450 payers to achieve a cohort representing 60% of the market, with a final respondent count of 200 to 250 most likely. CMS expects that greater than half of the payers we reach out to will participate, and among participants we will work to ensure greater than 90% completion of the data request.

Per the terms for the LAN's generic clearance, CMS initiated a pilot test on February 19th with 9 payers to improve our approach and lessen the collection burden. This pilot revealed useful information which lead to a more accurate burden estimate and key lessons learned for standardizing the methodology. On March 17th, CMS launched the National APM Data Collection website for a 30-day public comment period on the measurement methodology, survey tools, and frequently asked questions. The LAN advertised this website and the measurement effort through a variety of communication mediums (such as LAN newsletters, blogs, and webinars), while commencing with a robust payer recruiting effort for participation in this national effort that refers payers to the LAN's APM data collection website for comment and more detailed information associated with this information request. So far, 51 payers have committed to participate in this effort.

Based on this payer feedback during the pilot test and subsequent recruiting efforts, the LAN now anticipates that payers will experience differing levels of collection burden. Therefore, the LAN will have multiple options for reporting in an effort to maximize payer participation. Payers can report either "full details" or "partial details." Payers choosing to report "full details" will report dollars in categories 1-4 and subcategories related to the 2015 look back metrics and categories 3 and 4 and subcategories for the 2016 point-in-time metrics in the tabs for which payer has information (commercial, Medicare Advantage, and/or Medicaid). Payers choosing to report "partial details" will report dollars in categories 1-4 related to the 2015 look back metrics only and categories 3 and 4 related to the 2016 point-in-time metrics only in the tabs for which the payer has information (commercial, Medicare Advantage, and/or Medicaid). There is a desire to understand the prominence of particular APMs available across the nation; thus, payers that report the "full details" will receive a higher recognition from LAN than those reporting only "partial details." In addition, payers have the ability to report one or two market segments rather than all three (commercial, Medicare Advantage, Medicaid). Note that the burden estimate below assumes that all responses will contain the more burdensome, "full details" information.

For more detailed information on what the LAN intends to collect from payers who agree to participate in this national effort, please review the National APM Data Collection website content within the links on that website (and which are also found below):

- National APM metric overview and methodology
- Links to the excel files/collection tools for Medicaid, Medicare Advantage, and commercial lines of business
- Frequently Asked Questions
- APM Definitions

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

We anticipate no more than 440 responses for 2016. Data will be collected via the excel files/collection tools linked above. No incentives will be offered. The total approved burden ceiling of the generic ICR is 49,400 hours. We are requesting a total deduction of 13640 hours from the approved burden ceiling (440 participants x 31 hours = 13640 hours).

E. Timeline

This is scheduled to be an 8-week data collection effort that will run from May 18 – July 8, 2016.