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 early March 2016, 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.

To assess the adoption of APMs across the U.S. health care system, in 2016 the LAN launched a measurement effort focused on the adoption of APMs in the commercial sector, Medicare Advantage, and state Medicaid programs. The LAN structured its measurement efforts based on the work of the multi-stakeholder Alternative Payment Model Framework & Progress Tracking (APM FPT) Work Group, which had developed an APM Framework for categorizing APMs. In early 2016, nine participants from the LAN Payer Collaborative, a group of over 20 health plans and associations, volunteered to participate in a pilot of the survey instrument. The results of the pilot played an integral role in informing the data collection protocol and provided the LAN the opportunity to improve and maintain best practices moving toward a national effort.

Following the pilot, the LAN employed a multifaceted strategy (March-May 2016) to recruit health plans, and eventually Medicaid FFS states, to participate in a national effort to help gauge progress on the pathway to payment reform. In total, 70 leading health plans (over 100 plans including affiliates) and 2 states participated in an 8-week quantitative data survey from May 19 to July 13. Individual plan data, kept confidential, was aggregated into a composite number that serves as an indicator of APM adoption. These aggregated results were presented at the fall LAN Summit on October 25, 2016 and can be found on the LAN website.

Though the 2016 LAN survey is one of the largest and most comprehensive efforts to measure adoption of APMs conducted to date, there is still more work to be done. The LAN's proposed 2017 data collection initiative will build upon the 2016 baseline and will help CMS measure progress of APM adoption by the private sector and by state Medicaid programs. It will also enable further understanding of differences in APM adoption among commercial, Medicaid Managed Care, and Medicare Advantage plans.

B. Description of Information Collection

The purpose of this information request is to repeat, for purposes of measurement and comparison, the 2016 data collection by collecting health care spending data from commercial, Medicaid, and Medicare Advantage payers to track the health system's progress in adopting APMs. The goal is a consistent and harmonized "apples-to-apples" comparison of the various payment models in use nationwide.

The current APM Framework, which expanded and refined the CMS payment taxonomy, 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.

Using a revised version of the protocol used in the previous year's (2016) collection, health plans will be asked to provide an estimate of their spending in each of the APM Framework categories, as well as their total in- and out-of-network spend and total in-network spend, for CY 2016 or the most recent 12 months over all lines of business. This is a simplification of the 2016 protocol, which included multiple options for reporting data with varying levels of detail. In particular, the 2016 survey included two metrics, look back as well as point in time; the 2017 survey will include only the look back metric. Overall, the 2017 methodology will be similar to that of 2016.

Recruitment efforts to the 2017 LAN APM Measurement Effort will be reduced compared to 2016. The LAN will partner with America's Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA) and support participation of their member plans in the association APM survey. The LAN plans to recruit 20-30 non-member plans to submit data directly to the LAN.

Recruitment for the 2017 data collection will begin in April 2017, beginning with 2016 participants. As part of this recruitment effort, the LAN has launched a 2017 Progress Measurement website. The LAN will advertise this website and the measurement effort through a variety of communication mediums, such as LAN newsletters, blogs, and at the LAN Spring Forum.

For more detailed information on the 2016 effort, please visit the 2016 APM Progress Measurement website. This includes:

- The full 2016 Report
- 2016 APM progress measurement overview, background and methodology
- The original LAN APM Framework
- Additional resources, such as infographics, press release, plenary slides from the 2016 LAN Fall Summit and recorded webinars

The 2017 APM Progress Measurement website is designed to support participants in the 2017 LAN APM Measurement Effort. It includes:

- 2016 results
- Updated methodology

- Data Collection tool
- Frequently Asked Questions ([FAQ](FAQ))
- Link to the original APM Framework white paper

Document versions of the methodology overview and FAQ are attached to this request.

C. Deviations from Generic Request
No deviations are requested.

D. Burden Hour Deduction
Payer burden was collected for the 2016 effort, with an average of 23 hours per health plan. The protocol is reduced and simplified compared to 2016; additionally, a significant number of participants will be able to leverage the analyses established in 2016. For these reasons, the burden for 2017 should not exceed 23 hours per health plan.

The LAN is partnering with America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA), and will utilize the trade associations' aggregate data for their member health plans. In addition, the LAN will directly recruit up to 20-40 commercial plans and Medicaid FFS states to participate directly. In order to yield a meaningful representation of the US health care market, the survey aims to represent greater than 60% of covered lives. The objective is to build upon the 67% representation of the 2016 survey.

Data will be collected via a collection tool that will be posted on the 2017 Measurement Effort website. 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 1,150 hours from the approved burden ceiling (maximum 50 participants x 23 hours = 1,150 hours).

E. Timeline
This is scheduled to be an 8-week data collection effort that is scheduled to run from May 30-July 25, 2017.