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, the U.S. Department of Health and Human Services (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 here on the LAN website. The LAN repeated this strategy in 2017, managing to collect data from over 80 participants, accounting for nearly 245.4 million Americans, or 84%, of the covered U.S. population. This report was presented at the October 2017 LAN Summit and shows progress, with 29% of total U.S. health care payments tied to alternative payment models (APMs) in 2016 compared to 23% in 2015, a 6 percentage point increase.

In 2018, the LAN once again carried out a measurement effort, this time adding five simple informational questions about the current and future state of payment reform from the payer's perspective. The LAN surveys participants to understand LAN participant opinions, priorities, and issues with respect to how to best increase the adoption of alternative payment models. These additional five questions inform decision making about future LAN activities, including LAN Conference sessions, webinar topics, and feedback on LAN work group ideas. The LAN also included the informational questions in the 2019 effort. The LAN shared the 2019 results at the LAN Summit, finding that 35.8% of total U.S. health care payments were tied to alternative payment models (APMs) in 2018 compared to 29% in 2016, a 6.8% percentage point increase. The LAN reported the 2018 & 2019 results by line of business at the subcategory level using the definitions and categories provided in the Refreshed Framework. The LAN 2019 survey found that in the aggregate, 14.5% of dollars flowed through subcategories with two-sided risk payment models.

Though the 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 2020 data collection initiative will build upon the 2016 baseline and 2017, 2018, 2019 progress and will help CMS further understand differences in APM adoption among commercial, Medicaid, Medicare Advantage, and Traditional Medicare business.

B. Description of Information Collection

The purpose of this information request is to repeat, for purposes of measurement and comparison, the 2016, 2017, 2018 and 2019 data collection efforts by collecting health care spending data from commercial, Medicaid, Traditional Medicare 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, refreshed APM Framework, which expanded and refined the original 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.

Using a similar protocol from the 2016, 2017, 2018, and 2019 collection efforts, health plans and state Medicaid agencies will be asked to provide 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 2019 or the most recent 12 months over all lines of business. Similar to the 2018 and 2019 effort, the 2020 measurement effort will also ask five simple informational questions about the current and future state of payment reform. These questions are straightforward opinion-based questions from the payer's perspective. (See informational questions attachment for more information and the APM data collection tool to review each of the five questions.)

Recruitment efforts for the 2019 LAN APM Measurement Effort will be similar to 2019. In 2019, the LAN will again partner with America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) and support participation of their member plans in the associations' APM survey. Similar to 2018, both BCBSA and AHIP will voluntarily collect the same APM data the LAN is collecting, to capture payments by line of business. The LAN plans to recruit 50 health plans in 2019 to submit data directly to the LAN. Both AHIP and BCBSA will field their own surveys for their own purposes in alignment with the LAN's APM methodology. The LAN will receive aggregated data from AHIP and BCBSA, with no access to individual member plan responses.

Recruitment and notice for the 2020 data collection begin in April 2020, beginning with 2019 participants. As part of this recruitment effort, the LAN will launch a 2020 Progress Measurement website. The LAN will advertise this website and the measurement effort through a variety of communication mediums, such as LAN newsletters, blogs, LinkedIn page, and at the LAN events.

The 2020 APM measurement website will be designed to support participants in the 2020 LAN APM measurement effort. It will include:

- 2016, 2017, 2018, and 2019 APM results
- 2020 APM National APM Metric Overview (attached)
- Information on the 2019 APM Data Collection tool
  - A 508-Compliant pdf version of the data collection tool is attached, which will be administered via the Qualtrics platform
  - An Excel version of the 2019 metrics and definitions of key terms is attached for reference
- Frequently Asked Questions (FAQ) (attached)
- Link to the original and refreshed APM Framework white papers

Note that this 2020 APM measurement website is still under development. Document versions of the metric overview, FAQs, and survey tools are attached to this request.

C. Deviations from Generic Request
No deviations are requested.

D. Burden Hour Deduction
Payer burden was collected for the 2019 survey with an average of 18 hours per respondent, which includes the estimated two hours toward the informational questions first included in 2018. In 2020, an optional question measuring nominal risk in two-sided risk in subcategory 3B arrangements will be included for the first time. Because a significant number of participants are able to leverage the analyses established in 2016, 2017, 2018, and 2019, and the burden associated with the new nominal risk question is minimal (less than 7 hours), we are confident that the burden for 2020 will not exceed 25 hours per health plan.

For the fifth consecutive year, the LAN is partnering with AHIP and BCBSA who are fielding their own surveys for their own purposes in alignment with the LAN. In 2020, the LAN will receive aggregated data from AHIP and BCBSA, with no access to individual member plan responses. In addition to plans participating through AHIP and BCBSA, the LAN will directly recruit up to 50 commercial plans and Medicaid FFS states to participate directly. In order to yield a meaningful representation of the U.S. health care market, the survey aims to represent greater than 60% of covered lives, with the objective to build upon the 77% representation achieved in the 2019 survey.

Data will be collected via a Qualtrics collection tool that will be sent directly to participating payers. 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 1,250 hours from the approved burden ceiling (maximum 50 participants x 25 hours = 1,250 hours).

E. Timeline

The data collection effort is scheduled to run from May 26 - July 24, 2019. The results of the survey will be publicly reported at the LAN Summit to be held in October 2019.