Application to Use Burden/Hours from Generic PRA Clearance:
Health Care Payment Learning and Action Network
(CMS-10575, OMB 0938-1297)

Generic Information Collection (GenIC):

Tracking the adoption of alternative payment models (CMS-10620)

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. Due to the pandemic, the LAN conducted a "flexible measurement effort" in 2020, extending the submission period to allow plans to submit data until the end of CY 2020 and providing an option to submit two years of data in 2021. Results from 2020 (based on CY 2019 data) were reported concurrently with 2021 results (based on CY 2020 data) in late 2021. For 2022, the LAN will revert to its standard measurement effort, meaning plans will submit one year of data based on CY 2021.

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 2022 data collection initiative will build upon the 2016 baseline and 2017-2021 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, 2019, 2020, and 2021 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 past six years of data collection efforts, health plans and state Medicaid agencies will be asked to provide their spending in each of the APM Framework categories and subcategories, as well as their total in- and out-of-network spend, for CY 2021 or the most recent 12 months over all lines of business. Similar to the efforts since 2018, the 2022

measurement effort will also ask simple informational questions about the current and future state of payment reform. The additional two informational questions that were included in the 2021 survey will be revised and asked again in 2022. The additional two informational questions are intended to provide insights into payment reform trends that have emerged as a focus after the onset of the COVID-19 Public Health Emergency, namely health equity. All eight informational questions (the six original as well as the two new ones) 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 questions.)

Recruitment efforts for the 2022 LAN APM Measurement Effort will be similar to 2020 and 2021. In 2022, 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. Like prior years, 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 approximately 50 health plans in 2022 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 2022 data collection will begin in March 2022, beginning with 2021 participants. As part of this recruitment effort, the LAN will update the materials on the Measurement Effort Data Collection Process webpage. The LAN will advertise this webpage and the measurement effort through a variety of communication mediums, such as LAN newsletters, blogs, LinkedIn page, and at the LAN events.

The 2022 APM Measurement webpage will be designed to support participants in the 2022 LAN APM measurement effort. It will include:

- 2022 APM National APM Metric Overview (attached)
- The 2022 APM Data Collection tool
    - A 508-Compliant pdf version of the data collection tool will be provided. The data collection tool itself will be administered via the Qualtrics platform.
    - An Excel version of the 2022 metrics and definitions of key terms is attached for reference
- Updated 2022 Frequently Asked Questions (FAQ) (attached)
- Link to the original and refreshed APM Framework white papers

While the 2022 APM measurement webpage is live, it currently holds the 2021 versions of the resources listed above. Document versions of the 2022 metric overview, and FAQs are attached to this request.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Payer burden was collected for the 2020 and 2021 survey with an average of 27 hours per respondent, which includes the estimated two hours toward the informational questions first included in 2018. The 2022 will include a total of eight informational questions, a decrease of one question compared to nine informational questions in 2021. Because a significant number of participants can leverage the analyses established in 2016, 2017, 2018, 2019, 2020, and 2021, we are confident that the burden for 2022 will not exceed 27 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 2022, 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 approximately 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 Measurement Effort aims to represent greater than 60% of covered lives, with the objective to build upon the 72.5% and 80.2% representation achieved in the 2020 and 2021 survey, respectively.

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 of 1,350 hours from the approved burden ceiling (maximum 50 participants x 27 hours = 1,350 hours).

E. Timeline

The data collection effort is scheduled to run from May 23 - July29, 2022. The results of the survey will be publicly reported at the LAN Summit to be held in late 2022.