

## **Update: State Innovation Models Request for Information**

Since its inception, the Centers for Medicare & Medicaid Services (CMS) Innovation Center (Innovation Center) has recognized states as essential partners to achieving our common goals of better care for beneficiaries, better health for our communities, and lower costs. The Innovation Center has invested in multiple state-focused initiatives, including the State Innovation Models (SIM) Initiative in 2013 and 2015, the Maryland All-Payer Model in 2014, the Vermont All-Payer Accountable Care Organization (ACO) Model in 2016, and the Pennsylvania Rural Health Model in early 2017.

The health care landscape has evolved significantly since the Innovation Center's first SIM Initiative launched in 2013. In particular, the [Quality Payment Program](#), which implements the bipartisan Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) and was launched in 2017, provides significant payment incentives to promote participation in Advanced Alternative Payment Models (APMs), not just arrangements with Medicare, but also with Medicaid and private payers.

While CMS continues to facilitate national alignment around payment and delivery system transformation wherever possible, states are uniquely positioned to affect care delivery at the local level. Alignment across payers has the potential to reduce the administrative burden of health care providers participating in Advanced APMs, and to provide a rational business strategy for the infrastructure investment needed to transform care delivery.

In order to better understand stakeholders' views and interest in these concepts, the Innovation Center released a [Request for Information](#) (RFI) on State Innovation Model Concepts in September 2016. CMS received 67 responses from a variety of organizations, including 18 state governments, national constituency organizations representing states (National Governor's Association, National Association of Medicaid Directors, Association of State and Territorial Health Officials), national constituency organizations representing providers, policy/research organizations, philanthropies, consumer advocacy organizations, health systems, and payers.

We heard from the respondents that we should continue evolving our partnership with states, with four key themes serving as a guide for our next steps together. These themes will inform our work as we consider the next generation of support for state-led innovation models. Through the comments, CMS learned that:

- There is support for continued Innovation Center investment in state-led payment and delivery system reform initiatives.
- States may accelerate the adoption of Advanced APMs through support related to data, analytic capacity, measurement, and payment model infrastructure.

- Innovation Center support and assistance to states could help them adapt their existing multi-payer delivery and payment efforts in response to the Quality Payment Program.
- Targeted operational and policy changes among Federal agencies and CMS could facilitate and streamline successful implementation of state-focused models.

CMS looks forward to continued engagement with stakeholders who share our interest in fostering the success of states in achieving better care for beneficiaries, better health for communities, and lower costs in the health care system. All public comments that were received by the Innovation Center in response to the RFI are available at <https://innovation.cms.gov/initiatives/State-Innovations/>.

**Public Response To  
Center for Medicare and Medicaid Innovation  
Request for Information on State Innovation Model Concepts**

1. AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS
2. SUZY Q CLEANING SERVICE LLC
3. TACTICAL STRATEGIES, LLC
4. AMERICAN ACADEMY OF PEDIATRICS
5. NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION
6. VIRGINIA
7. MILBANK MEMORIAL FUND
8. LEARNING COLLABORATIVE ON HEALTH EQUITY AND YOUNG CHILDREN
9. ROBERT WOOD JOHNSON FOUNDATION
10. HIMMS ELECTRONIC HEALTH RECORD ASSOCIATION
11. WEST VIRGINIA
12. TENNESSEE
13. NEVADA
14. ARKANSAS
15. CONNECTICUT
16. DISABILITY ADVOCATES ADVANCING OUR HEALTHCARE RIGHTS (DAAHR)
17. CENTER FOR IMPROVING VALUE IN HEALTH CARE
18. ASTHO
19. APCD COUNCIL
20. OFFICE OF HEALTH CARE STATISTICS UTAH DEPARTMENT OF HEALTH
21. KITCHEN CABINET AND THE COLLABORATIVE INNOVATION NETWORK OF THE  
LEARNING COLLABORATIVE ON HEALTH EQUITY AND YOUNG CHILDREN
22. CENTER ON BUDGET AND POLICY PRIORITIES
23. LOUISIANA MEDICAID
24. UNITEDHEALTHCARE
25. HEALTH PARTNERS
26. OKLAHOMA
27. CONSUMERS UNION
28. PREVENTION INSTITUTE
29. NATIONAL ASSOCIATION OF MENTAL HEALTH PROGRAM DIRECTORS  
(NASMHPD)
30. GUTTMACHER INSTITUTE
31. HEALTH CARE TRANSFORMATION TASK FORCE
32. MAINE HEALTH MANAGEMENT COALITION
33. MINNESOTA ACCOUNTABLE HEALTH MODEL (SIM) MINNESOTA DEPARTMENT  
OF HUMAN SERVICES
34. OREGON MEDICAID

36. NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT
37. BLUE CROSS BLUE SHIELD OF MICHIGAN
38. NEW YORK
39. NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION
40. UNITYPOINT HEALTH
41. NATIONAL HEALTH COUNCIL
42. CENTER FOR CONSUMER ENGAGEMENT IN HEALTH INNOVATION COMMUNITY CATALYST
43. NORC
44. HEALTH PEOPLE
45. TRINITY HEALTH
46. MARYLAND
47. SPECTRUM HEALTH SYSTEM
48. STATE HEALTH AND VALUE STRATEGIES
49. NATIONAL ASSOCIATION OF MEDICAID DIRECTORS
50. NATIONAL ACADEMY FOR STATE HEALTH POLICY (NASHP)
51. AETNA
52. RHODE ISLAND
53. NATIONAL GOVERNORS ASSOCIATION
54. FREEDMAN HEALTHCARE
55. NEW MEXICO
56. GEORGETOWN UNIVERSITY
57. NCQA
58. AMGA
59. PLANNED PARENTHOOD
60. MENTAL HEALTH AMERICA
61. MAINE
62. AMERICAN PSYCHIATRIC ASSOCIATION
63. BIOTECHNOLOGY INNOVATION ORGANIZATION
64. WASHINGTON, D.C
65. AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, INC.
66. COLORADO
67. WASHINGTON
68. UNIVERSITY OF IOWA DIVISION OF CHILD AND COMMUNITY HEALTH

October 20, 2016

Patrick Conway, MD, MSc Deputy Administrator for Innovation and Quality Center for Medicare and Medicaid Innovation Centers for Medicare and Medicaid Services Department of Health and Human Services 200 Independence Avenue, SW Washington, DC 20201

**Re: Request for Information on State Innovation Model Concepts**

Dear Dr. Conway:

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 57,000 physicians and partners in women's health, I am pleased to have the opportunity to respond to the Center Medicare and Medicaid Services' (CMS) Request for Information (RFI) on State Innovation Model (SIM) Concepts. We believe the health care delivery system transformation underway has the potential to expand access, improve care experience and outcomes, and lower costs for all people. However, unless alternative payment and delivery system models recognize the centrality of reproductive health to women's well-being, significant opportunities will be lost. Obstetrician-gynecologists (ob-gyns) are the primary or exclusive source of health care for many patients, particularly women of reproductive age. We believe that advancing health equity among women of reproductive age requires strategies that elevate comprehensive reproductive care in integrated systems.

ACOG looks forward to working with CMS in the ongoing development of system transformation at the national and state level. Improving women's health care and outcomes should be a priority as new payment and care delivery models are designed, implemented, and evaluated. It is with these goals in mind that we submit the following comments.

**What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?**

We strongly believe that successful reforms must proceed from processes that include a wide spectrum of providers and their patients. Patients and reproductive health providers must collaborate and engage in all levels of development and implementation of payment and delivery system reform to ensure that women's unique health needs are met by reform efforts. In doing so, there must also be recognition That obstetrician-gynecologists (ob-gyns) are often women's main care providers and can deliver both primary, preventive care as well as specialty care. Models should recognize the role and value of reproductive health providers in treating, coordinating care, and providing community supports for women of reproductive age who have chronic or complex health conditions.

Public and private investments must be adequate to build and sustain capacity for ob-gyns and reproductive health providers to participate effectively in new payment models and to provide the highest quality care for their patients. Investments should support workforce strategies that ensure capacity for ob-gyns to play lead roles in high-quality, interdisciplinary care. We believe that priority should be given to enabling ob-gyns and women's health providers to adopt and maintain state-of-the-science information technology.

Payments to reproductive health providers should take into account the full value of the services they offer along the spectrum of care, including the value of preventing unintended pregnancies, sexually transmitted infections (STIs), and cancer, and of treating the mother-infant dyad. These models must also provide women ready access to the full range reproductive health care and other preventive services related to contraception, abortion, STI screening and treatment, and maternity care. Financial incentive programs should balance cost-saving interests at the system level with patient preference, quality performance, and health outcomes at individual and population levels. Models should not interfere with the ability of patients to choose the reproductive health services and supplies (such as a method of contraception) that best fit their needs and preferences at various points in their reproductive lives and should afford every patient flexibility and autonomy in reproductive planning over their lifespan. Payment reform programs must also guard against coercion or withholding care by ensuring patients' abilities, preferences, and values are respected.

Inclusion of a wide spectrum of providers is essential. Multi-payer reform cannot be driven only by the health needs of the Medicare population, but must encompass patients throughout their life span with the input of the physicians who care for them. Inclusion of ob-gyns in the development and implementation of delivery system and payment reform is key to ensuring that women's unique health needs are met by reform efforts. There must also be recognition that ob-gyns are often women's primary care providers and that ob-gyns can provide both primary, preventive care as well as specialty care.

With these concerns in mind, ACOG would caution against the second proposed model that incentivizes states to align with Medicare models because we believe it will continue to ignore the health needs of significant portions of the populace. Allowing Medicare to drive alignment will send the message to payers and policymakers that the health of women of reproductive age is unimportant. While we think there should be a role for incubation at the federal level, innovation cannot continue to be driven solely by the Medicare program if the ultimate goal is population-level improvements.

**Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment?**

Women's health and reproductive health care providers need access to timely data about their patient panels in order to appropriately manage care. Medicare and Medicaid need to provide feedback on performance in each of those programs, whether that is on cost data or reported quality metrics, in order to facilitate improvement. Incentivized quality improvement efforts should focus on eliminating

reproductive health disparities and reducing the rate of unintended pregnancy. Efforts should recognize appropriate roles for ob-gyns in improving health outcomes and care.

There must also be alignment in quality and cost measurement methodologies across payers and common definitions for payment models. If payers are instituting episode groups, there must be standardization about the package of services that are included and the risk adjustment methodologies that will be employed. Ob-gyns cannot function in an environment where every payer has different reporting requirements and modified packages of services because the administrative burden will be too high.

Integrated delivery systems should be accountable for meeting the diverse health care and coordination needs of all patients of reproductive age. Care delivery should not be based on a one-size-fits-all model, and patients should be able to choose the provider who is responsible for coordinating their care, so long as that provider is qualified, willing, and able to assume the responsibility. Payment for care coordination should reflect the value of preventive services and supportive services, based on methodologies that consider quality improvement and cost avoidances over patient lifespans. Further, payment models should be available that explicitly recognize that for some patients and patient populations, ob-gyns may be best positioned to engage the patients and ensure that the patient's care is appropriately comprehensive and coordinated.

**How can CMS support improved access to and linkage with health outcomes measures data?**

CMS should work to accelerate measure development in the area of reproductive health, including maternity care and family planning. We believe that CMS should devote resources that further the inclusion of patient-generated data, such as patient-reported outcomes, and patient experience of care into payment models. Models must include a sufficient number of quality measures on reproductive health and the preventive services provided in reproductive health settings. These measures should include, but not be limited to, contraceptive use and counseling and screening for BMI, cancer, STI, depression, tobacco use, and intimate partner violence. While not all of these measures may be suitable for assessing quality at the individual provider or practice level, they may be appropriate barometers of access to care within integrated delivery systems or at the population level.

**Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.**

ACOG recommends that CMS evaluate the feasibility and success of a women's medical home per authorizing statute for the Center for Medicare and Medicaid Innovation.<sup>1</sup> While ACOG appreciates that CMS is currently investigating pregnancy medical homes' impact through the Strong Start program, we believe that CMS should also examine a medical home for women that is broader. Because only some of the certifying bodies that provide accreditation or certification recognize obstetrics and gynecology practices as eligible to become patient-centered medical homes, many ob-gyns have not pursued this type of formal practice transformation. ACOG believes that CMS can and should dedicate resources to help ob-gyns make the necessary infrastructure and staffing investments through SIM or other demonstrations to pilot women's medical homes.

**How can CMS/HHS better align in order to support state delivery system reform efforts?**

The Centers for Medicare and Medicaid Services must improve the timeliness of its data systems for both Medicare and Medicaid in order to align with private payers. For Medicaid data, this also requires improvements by standardizing data definitions across state programs. This will allow policymakers to make comparisons and identify successful strategies that may be able to be replicated in other state Medicaid programs.

Again, thank you for the opportunity to comment on the Request for Information on State Innovation Model Concepts. We hope you have found our comments helpful. We look forward to working with CMS as it continues its payment and delivery system transformation work. Should you have any questions, please contact Elizabeth Wieand, Program Director of Payment and Delivery System Policy, at [ewieand@acog.org](mailto:ewieand@acog.org) or 202-314-2356.

Sincerely,

Barbara S. Levy, MD, FACOG, FACS Vice President, Health Policy



Medicaid and Medicare,

Being 56, disabled, and realizing each day I am getting older, "The assurance that I will have someone to assist me with my needs when I am older is important to me." I am president of Suzy Q Cleaning Service LLC which is certified as a Housekeeping Apprenticeship with the United States Department of Labor, and licensed Personal Service Agency with Indiana State Department of Health, certified Waiver provider with Family Social Service Administration, and Healthcare programs providing Home and Community Based Services to ensure a quality of life for Aged & Disabled, Traumatic Brain Injury, and The Money Follows The Person, and who trains employee/apprentices in all aspects in housekeeping, behavioral management, dementia, elder care, attendant care, patient care, homemaker services, ground maintenance, building maintenance, and housing solutions which we believe a "Well trained staff will provide exceptional service for those who rely on our services." Suzy Q Cleaning Service LLC is not able to receive our share of clients, because lack of knowledge on CIOCA care managers behalf, "Who insist they do not recommend providers to client for services, but I have found this not to be true." I am requesting that training provider which train employees/apprentices be able to demonstrate their abilities in providing quality services for client and consumers, and ensure our workforce receives employment which assist Indiana's overall demand, "That all citizens have a right to a quality and healthy life, "With well trained qualified professional provider ensuring safety and security for the future for those who depend on us."

Thank you,

Suzy Q Cleaning Service LLC

Suzett Moffitt/President/Manager/Apprenticeship

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Innovation is about  
*imagining the possibilities*

Not sure where to start,  
but know where you have  
to go?



Consumer  
Engagement

Integrated  
Systems



Big Data  
Analytics

Trusted  
Advisor



## business transformation is about connecting the dots...

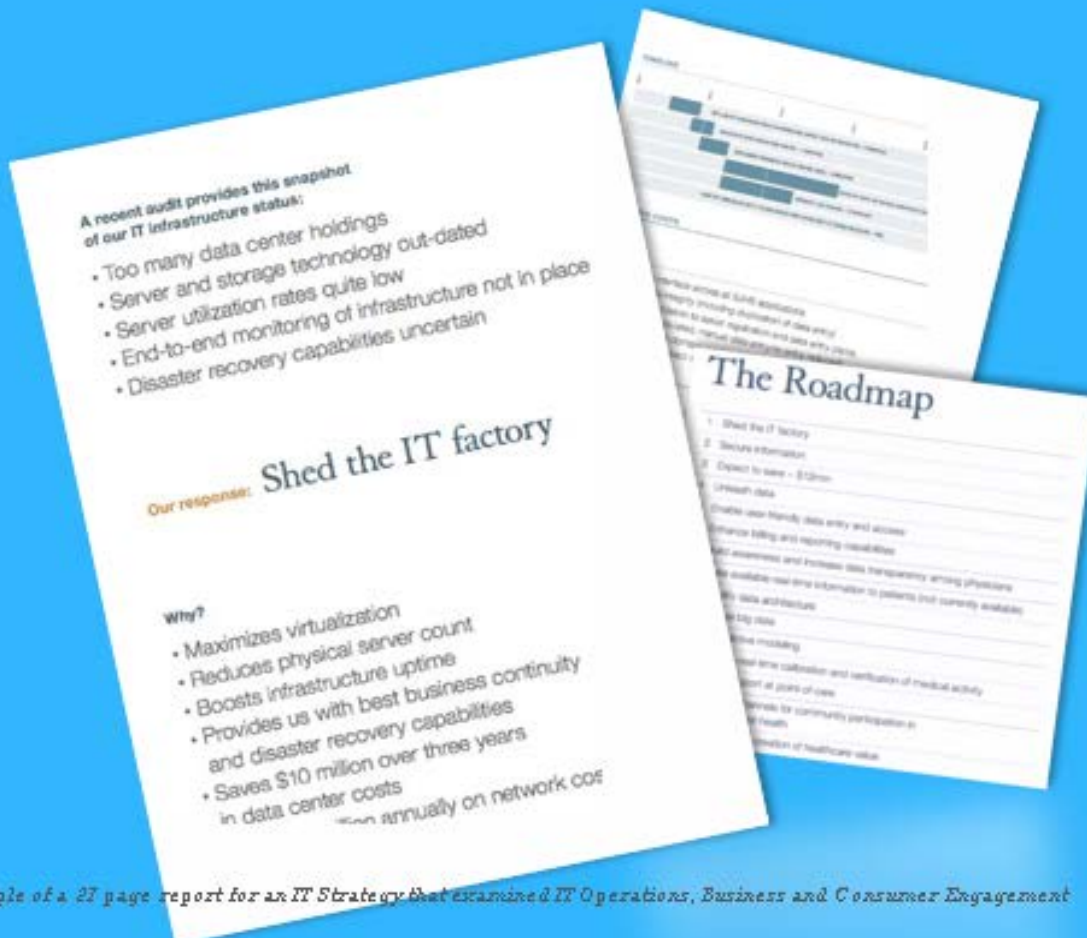
The...  
Right Technology  
Right Workflow

Engaging Experiences

Strategic	Tactical	Point Solutions
<ul style="list-style-type: none"><li>• System Integration</li><li>• Big Data</li><li>• Consumer Engagement</li><li>• IT Utility, Cloud Migration</li><li>• IT Strategic Roadmap</li></ul>	<ul style="list-style-type: none"><li>• Project Management</li><li>• RFP/RFI Management</li><li>• Application Rationalization/ <del>Sunsetting</del></li><li>• Data Center Migration</li></ul>	<ul style="list-style-type: none"><li>• Consumer Portals</li><li>• Data Viewer (Connect Disparate Transactional Systems)</li><li>• Analytics / Quality</li><li>• Workflow Optimization</li></ul>
<ul style="list-style-type: none"><li>• <del>Cost Reduction Planning- LEAN</del></li><li>• IT Organization Analysis</li><li>• System Architecture</li></ul>	<ul style="list-style-type: none"><li>• Vendor Management</li><li>• Project/Risk Audits</li><li>• IT Staffing Perm/Project</li></ul>	<ul style="list-style-type: none"><li>• ODS/EDW/BI</li><li>• Asset Management</li><li>• Enterprise Service Bus</li></ul>
<ul style="list-style-type: none"><li>• Organizational Structure</li></ul>	<ul style="list-style-type: none"><li>• Technology Selection</li><li>• CRM</li></ul>	<ul style="list-style-type: none"><li>• Application Archival</li><li>• Service Desk</li></ul>



# Strategy – Radically Simplified



Sample of a 23 page report for an IT Strategy that examined IT Operations, Business and Consumer Engagement



Identify  
Analyze  
Mitigate

Complexity Unraveled

October 19, 2016

Patrick Conway, MD, MSc, FAAP Deputy Administrator, Center for Medicare and Medicaid Innovation  
Chief Medical Officer, Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore,  
MD 21244

Dear Dr. Conway:

On behalf of the American Academy of Pediatrics (the “Academy” or “AAP”), a non-profit professional organization of 66,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, I write to comment on the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation’s (CMMI) Request for Information (RFI) on State Innovation Model Concepts.

The Academy appreciates CMMI’s ongoing work in the area of state-based initiatives and welcomes the opportunity to provide a pediatric perspective. In the RFI, CMMI states that “the multi-payer models enabled by Medicare participation hasten momentum among states to use their levers to accelerate payment and delivery transformation on a broad scale, and thereby enable states to use their unique capacity to affect improvements in the health of the entire state population.” Children make up almost half of all Medicaid enrollees, but because of the Medicare centric nature of many recent innovative payment models pediatrics is often excluded. For example, pediatrics is implicitly excluded from participation in CMS’s new Comprehensive Primary Care Plus program because in order to qualify, a practice must meet a Medicare patient threshold, something that is unlikely in pediatrics.

Medicaid and private payers often adopt Medicare policies even though those structures were created to meet the needs of adult practice and are often inappropriate, inapplicable, or unworkable in pediatrics. Imposing adult structures on pediatrics may unnecessarily increase cost without the gain of a corresponding benefit. The Academy urges CMMI to consider the unique needs of pediatric populations and identify payment models that reflect the unique emphasis on prevention and healthy growth and development that is the foundation pediatric primary care. Only by designing a payment system with children in mind at the beginning will the healthcare system produce quality care, improved outcomes and lower costs.

The Academy’s comments to specific portions of the RFI follow below.

## **Section I: Multi-Payer State-Based Strategies to Transition Providers to Advanced Alternative Payment Models**

The proposals contained in Section I do not appear to be fully inclusive of pediatrics. The first proposed pathway, “a state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation,” purports to be inclusive of all payers, but CMMI states that the proposed multi-payer model must be based on Medicare participation and must align with Medicare Advances Alternative Payment Model (AMPs) principles which could pose many challenges to pediatric participation. One example of these potential challenges is the use of electronic health records (EHR). In order for a Medicaid medical home to qualify for an APM payment, the model must show that health information technology is meaningfully used. This poses a problem in pediatrics because pediatricians have the lowest rate of fully-functional health IT penetration: only 8% of pediatricians have (EHR) systems with what pediatric informatics consider full functionality.<sup>1</sup> Complicating matters, practices cannot count children in stand-alone CHIP programs in their case mixes to qualify for Medicaid incentive payments, which means that many pediatricians will not be able to meet the case mix threshold in order to qualify for the incentive payment.

Another potential problem is the lack of appropriate pediatric quality measures in current payment models. For example, in the AAP’s comments to CMS-5517-P Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician Focused Payment Models, we noted that of the 30 pediatric-specific measures listed in the rule, only three were from the Children’s Health Insurance Program Reauthorization Act (CHIPRA) pediatric quality core set.<sup>2</sup>

The second proposed pathway, “support[ing] states to align with existing Medicare models” such as CPC+, is equally problematic. The system for pediatric practice centers around the medical home, a concept originated by pediatricians with families. A family-centered medical home is an approach to providing comprehensive primary care; in a family-centered medical home, the pediatric care team works in partnership with a child and a child’s family to meet all of a child’s medical and health-related needs. Through this partnership, the pediatric care team can help the child and child’s family access, coordinate, and understand services that are important to the child’s health. The family-centered medical home delivers primary care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective to all children and youth, including children and youth with special health care needs (CYSHCN).

Despite the strong success of the family-centered medical home, pediatrics is excluded from models like CPC+ due to a lack of Medicare participation. CMMI should encourage states to adopt payer models that include a realistic application of the APM qualification standards to pediatrics; define “medical home” in such a way to capture the special characteristic and needs of children, and include robust and streamlined measures of pediatric quality.

## **Section II: Assess the Impact of Specific Care Interventions Across Multiple States**

The Academy applauds the efforts of CMS and CMMI, through both the State Innovation Model (SIM) initiative and other ongoing activities, to help states develop and spread new and promising practices across the country. CMS/CMMI work to directly support state design and testing of new delivery system

and payment models has been groundbreaking, and these efforts will provide a direct and lasting impact on the future of care for children in the Medicaid program.

Medicaid-led system transformation is of critical interest to the Academy. Medicaid plays a vital role in the health and well-being of millions of children across the country and Medicaid reforms have the potential to significantly impact pediatric practice. Medicaid truly serves as the backbone of health care coverage for children in the United States. Medicaid led innovations toward value based payment and other alternate payment models (APMs), accountable care, inclusion of social determinants of health, population health, improved quality measurement, and other reforms are critically important for pediatrics.

Given the unique characteristics of Medicaid and the nature of its federal-state partnership, the Academy recognizes the inherent challenges in standardizing a care intervention across states. That said, we applaud this effort as a assured step forward in the evolution of Medicaid design and testing and the CMS/CMMI commitment toward achieving the Triple Aim.

The Academy recognizes a number of state innovations and reform models to date have focused more acutely on care for adults, given the potential for greater cost savings and a more immediate return on investment. However, the Academy stresses the importance of high quality continuous care over the life span and the critical importance childhood preventive care plays as children age into adulthood. The multi-state care intervention proposal contemplated in this RFI presents an important opportunity to further assess care intervention impacts in various settings, markets, payment structures, and delivery systems.

The AAP is uniquely positioned to be a resource to CMS/CMMI in the development of pediatric care interventions that might be tested across state Medicaid programs. At the national level, the AAP is the home to 90 committees, councils, and sections, which help guide the Academy in its development of pediatric policy, clinical reports, technical reports, and practice guidelines; educational programming and resources; advocacy initiatives; and the translation of policy and education into pediatric practice. The AAP is the professional home to over 66,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists, who look to the Academy for expert clinical recommendations and best practices.

Moreover, the AAP and its 59 state AAP chapters provide a nationwide network of pediatric expertise, with significant Medicaid policy experience at the state and federal levels. The Academy, through its Chapter Quality Network (CQN), helps AAP chapters and member pediatricians learn to apply evidence-based guidelines to standardize care and, over time, use quality improvement to embed reliable care systems into everyday practice. The AAP Quality Improvement Innovation Networks (QuIIN) is home to multiple pediatric quality improvement networks designed to improve care for children and their families in both the inpatient and outpatient settings. QuIIN achieves this through process improvement in everyday pediatric practice as well as by informal assessment that offers practicing pediatrician perspective into evidenced based recommendations and tools for implementation.

Because of the critical role Medicaid plays in the health care of children, we urge CMS/CMMI to develop and assess care interventions specific to pediatrics through work stemming from this RFI. Further and given the AAP's expertise in child health, we encourage CMS/CMMI to work with the AAP in

development of these interventions.

As a potential starting point, the centerpiece of pediatric primary care is Bright Futures. Included in the Affordable Care Act, Bright Futures is a national health promotion and prevention initiative, led by the AAP and supported by the Maternal and Child Health Bureau, Health Resources and Services Administration. The Bright Futures Guidelines provide theory-based and evidence-driven guidance for all preventive care screenings and well-child visits.

Bright Futures content can form the foundation of a reimagined payment system that supports the best primary care for children. The strength of this foundation is that it is designed from the beginning with children in mind—not merely an adaption of adult structures for children. And further, the overarching goal of Bright Futures is resilient and healthy children that reach adulthood with optimum wellness. Improving the health and wellbeing of children has lifelong effects and will result in improved health outcomes and lower costs across the lifespan.

If you have any questions or concerns regarding the Academy's comments contact Caitlin Van Sant (cvansant@aap.org) in the Academy's Washington, DC office. Thank you for the opportunity to share the views of the American Academy of Pediatrics.

Sincerely,

Benard P. Dreyer, MD, FAAP President

BPD/cvs



October 24, 2016

Patrick Conway, MD, MSc  
Deputy Administrator for Innovation and Quality  
Center for Medicare and Medicaid Innovation  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Request for Information on State Innovation Model Concepts**

Dear Dr. Conway:

The National Family Planning & Reproductive Health Association (NFPRHA) thanks you for the opportunity to provide comments in response to the Request for Information (RFI) on State Innovation Model (SIM) Concepts.

NFPRHA is a national membership organization representing the nation's publicly funded family planning providers – nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private non-profit organizations.

NFPRHA believes that the health care delivery system transformation underway has the potential to expand access, improve care experience and outcomes, and lower costs for all people. However, NFPRHA is concerned that delivery system and payment reform efforts to date have missed a critical opportunity and need to engage and include family planning and sexual health providers—and the millions of women and men they serve each year—in these efforts to improve health outcomes and lower health care costs.

Supported by federal investments, most states are pursuing ambitious agendas to move health care financing from the traditional volume-based, fee-for-service approach to value-based models. The focus of these transformational initiatives has been primarily on Medicare enrollees and Medicaid beneficiaries with chronic health care needs or complex conditions. As health system transformation races forward, model designers and policymakers must deliberately consider how to meet the unique

health care needs of women and men of reproductive age, including prioritizing access to family planning and sexual health care.

Family planning and sexual health providers are the primary or exclusive source of health care for many patients, particularly women of reproductive age. As the Center for Medicare and Medicaid Services (CMS) continues to develop and implement new models of care and financing, NFPRHA believes that essential family planning and sexual health care by providers who serve these populations must be effectively prioritized and integrated. NFPRHA strongly believes that addressing this issue is essential to improving health outcomes, preventing chronic conditions, and yielding significant system-wide cost savings.

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NFPRHA believes that successful reforms must proceed from processes that include a broad spectrum of providers and their patients. Family planning and sexual health providers must be engaged in all levels of development and implementation of payment and delivery system reform to ensure that the unique health needs of their patients are met by reform efforts. In doing so, there must also be recognition that family planning and sexual health providers are often the primary, and sometimes only, source of health care for millions of people of reproductive age, particularly women. Models should also recognize the important role these providers play in coordinating care and providing community supports for women and men of reproductive age, many of them low-income or underserved with complex health conditions.

Public and private investments must be adequate to build and sustain capacity for family planning and sexual health providers to participate effectively in new payment models and to provide the highest quality care for their patients. Investments should support workforce strategies that ensure capacity for these providers to play lead roles in high-quality, interdisciplinary care. Priority should be given to enabling family planning and sexual health providers to adopt and maintain state-of-the science information technology.

Payments to family planning and sexual health providers should take into account the full value of the services they offer along the spectrum of care, including the value of preventing unintended pregnancies, sexually transmitted diseases (STDs), and cancer. These models must also provide women and men ready access to the full range reproductive health care and other preventive services related to contraception, abortion, and STD screening and treatment. Financial incentive programs should balance cost-saving interests at the system level with the unique needs of these patients, quality performance, and health outcomes at individual and population levels. Models should not interfere with the ability of patients to choose the health services and supplies (such as a method of contraception) that best fit their needs at various points in their reproductive lives. Models should further recognize the unique ways in which men and women of reproductive age—and particularly low-income and underserved women—experience the health care system and seek out care, and should afford every patient flexibility and autonomy in reproductive planning over their lifespan. Payment reform programs must also guard against coercion or withholding care by ensuring patients' abilities, needs, and values are respected.

Multi-payer reform cannot be driven only by the health needs of the Medicare population, but must encompass patients throughout their life span with the input of the providers who care for them. With these concerns in mind, NFPRHA would caution against the second proposed model that incentivizes states to align with Medicare models, as this would continue to ignore the health needs of significant portions of the populace. Allowing Medicare to drive alignment will send the message to payers and policymakers that women's health and patients' family planning and sexual health needs are unimportant. Innovation cannot continue to be driven solely by the Medicare program if the ultimate goal is population-level improvement.

Integrated delivery systems should be accountable for meeting the diverse health care and coordination needs of all patients of reproductive age. Care delivery should not be based on a one-size-fits-all model, and patients should be able to choose the provider who is responsible for coordinating their care, so long as that provider is qualified, willing, and able to assume the responsibility. Payment for care coordination should reflect the value of preventive services and supportive services, based on methodologies that consider quality improvement and cost avoidances over patient lifespans. Further, payment models should be available that explicitly recognize that for some patients (or patient populations) family planning and sexual health providers may be best positioned to engage the patients and ensure that the patient's care is appropriately comprehensive and coordinated.

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NFPRHA appreciates the opportunity to comment on the Request for Information on State Innovation Model Concepts, and would welcome the opportunity to further discuss some of the issues raised in this letter.

NFPRHA looks forward to working with CMS as it continues its payment and delivery system transformation work. Please contact Robin Summers at 202-293-3114 ext. 227 or at [rsummers@nfprha.org](mailto:rsummers@nfprha.org) if you have any questions or would like additional information.



Sincerely,

Clare Coleman  
President & CEO

# **VIRGINIA'S RESPONSE TO REQUEST FOR INFORMATION ON STATE INNOVATION MODEL CONCEPTS**

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October 26, 2016

Dear Secretary Burwell and Acting Administrator Slavitt:

It is my pleasure to submit a response to the State Innovation Model (SIM) Request for Information on behalf of the Commonwealth of Virginia and our SIM lead partner, the Virginia Center for Health Innovation. Together, we have been hard at work for the past four years, in collaboration with a wide range of stakeholders, to develop a State Health Innovation Plan that is both responsive to the CMS national vision for payment and delivery system reform and consistent with the dynamics of our own Virginia health care marketplace. We believe we are making significant progress to align these two and advance value-driven care for our citizens. We look forward to working with CMS to make further advances and appreciate your interest in our input as you work to support broad payer and health care provider participation in alternative payment models that could be Advanced Alternative Payment Models under the Quality Payment Program.

At present, Virginia is focused on the following priorities:

Transforming Medicaid to a system that financially rewards value. Ours is a comprehensive approach, which includes transitioning our remaining populations (Managed Long Term Services and Support) into managed care and re-procuring existing managed care contracts (Medallion) in 2017. Through these renegotiations, Virginia Medicaid has an opportunity to leverage all MCO contracts, and potentially a DSRIP program, to facilitate movement towards APMs in Virginia, where plans and providers alike can transition to value centric payment structures.

Aligning payment incentives across the majority of our providers' patient bases. Aligning Medicare and Medicaid incentives will provide achievable scale to incent provider change. Virginia is moving towards APMs and Medicare's participation would be a catalyst to drive multi-payer alignment.

Enhancing our statewide HIE infrastructure to support better data analytics and enable easy access for providers interested in participating in payment reform.

Educating health care providers as to the merits of advanced payment models and preparing them to participate.

We look forward to a continued partnership with CMS to support and advance these aims. We eagerly await a SIM Round 3 announcement, having invested significantly in completing the requirements of the Round 2 Design process. We also are eager to



finalize our DSRIP waiver so that we can advance meaningful payment and delivery system reform that will begin with some of Virginia's most high need, at-risk patients and spread to our entire population.

If, after reading these comments, you would like additional information, I would encourage you to reach out directly to me or our state SIM lead, Beth Bortz. Our contact information is provided below.

Sincerely,

A handwritten signature in black ink, appearing to read "William A. Hazel, Jr.", with a stylized, cursive script.

William A. Hazel, Jr., MD

Virginia Secretary of Health and Human Resources

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## SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

**Part 1: What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?**

### **Introduction:**

While a small number of large provider systems in Virginia participate in select models that CMS may consider an advanced alternative payment model (AAPM) under Medicare, movement towards broader, multi-payer adoption of such models has been slow. Virginia is not a Comprehensive Primary Care Initiative (CPCI) or Comprehensive Primary Care Plus (CPC+) state and our health plans are not presently aligned around a unified approach to incentivize the adoption of Patient Centered Medical Homes. Consequently, most of our providers are not engaged and have spent limited time preparing to engage in an AAPM under the quality payment program. Instead, they struggle daily to engage in the dozens of different programs that individually serve a small percentage of their patients and require strong performance on a wide and often conflicting range of metrics. Unlike many of our neighboring states, Virginia has received limited federal financial support to address this challenge. Our legislative leadership sees reforming Medicaid payment and delivery systems as distinct from Medicaid expansion. So, while Virginia Medicaid is committed to participating in a multi-payer advanced alternative payment model, we will need help from CMS to make this a reality. Virginia needs flexibility to successfully prepare inexperienced providers for broad-based, multi-payer AAPM adoption and modifications to Virginia's Medicaid managed care environment.

There is growing interest in the Virginia payer community to work together to advance a true multi-payer AAPM that meets the Qualified Payment Program guidelines and includes Medicaid, Medicare, and several commercial plans. We are finding that while individual payers have developed alternative payment models (APMs), current uptake by providers is very limited. Payers need assistance educating physicians about the merits of these programs and preparing them for participation. They also need assistance at the state level to address the data sharing challenges that will have to be resolved if care management is to improve and cost of care is to be captured and managed. The Virginia Center for Health Innovation (VCHI), Virginia's State Innovation Model (SIM) lead, is well suited to play a neutral convening role to bring stakeholders together and tackle the aforementioned challenges, especially as it currently is the Implementation Lead on an Agency for Healthcare Research and Quality (AHRQ) practice transformation initiative (EvidenceNow) that involves 228 primary care practices from all regions of the state. Our partnerships with the provider community are strong and include support from

the medical specialty societies, the health systems, the Federally Qualified Health Centers (FQHCs), the Clinically Integrated Networks (CINs), and private practices. They recognize that The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation provides a new incentive for providers to enter into risk bearing relationships. But before they can better bear risk, they need to be able to assess their baseline performance, identify practice improvement strategies, and make real time course corrections. While not all of Virginia's commercial plans are likely to work together at first, we believe we can reach a critical threshold of engagement if both Medicaid and Medicare join with those that are already willing.

**Part 1A. What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?**

To achieve all payer alignment in Virginia, there must be alignment of stakeholder incentives and quality reporting. A statewide health information exchange, which must include ubiquitous provider and payer participation, will provide the data infrastructure necessary to collect and analyze information needed for better care coordination and payment reform. Alignment across all payers will strengthen Virginia's delivery system and facilitate transition to APMs. While this is the vision for Virginia, the Commonwealth is faced with several current challenges that may slow or block this effort.

**Current Challenges:**

An important factor in Virginia's transition to alternative payment models is supporting large-scale transition away from the traditional fee for service (FFS) delivery system. Similar to other states, Virginia's delivery system is still predominantly oriented towards fee for service (FFS) payment arrangements at the provider level. Seventy-five percent of Virginia Medicaid recipients are enrolled in managed care, however, a majority of Medicaid managed care reimbursement to providers is still largely FFS. MCOs currently have provider networks based on FFS arrangements and the few existing incentive contracts depend on claims-based data, not clinical outcomes data.

Medicare is also predominantly FFS in Virginia. Some large hospital-based systems in the Commonwealth have Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), but none bear downside risk. Virginia has no CPCI or CPC+ participation; although a critical mass of health plans did apply for the original CPCI demo. There are a few Bundled Payments for Care Improvement (BPCI) participants and Virginia successfully launched a care transitions pilot that generated improved outcomes and substantial savings before its conclusion.

There are some Patient Centered Medical Home (PCMH) programs operating in Virginia under commercial insurance payers, but each is distinct with their own requirements, metrics, and financial incentives. Additionally, a small number of Virginia ACOs, and some hospital systems, have developed clinically integrated networks to contract with payers and coordinate care management; however, even within those

models, the number of incentive contracts based on clinical quality reporting is limited. Much remains to be done to transition Virginia's health care reimbursement structure from predominantly FFS to APMs.

One particular challenge to large-scale transition from FFS to APMs is achieving the needed stakeholder engagement and support. Supportive and engaged stakeholders understand the value to their business and the entire delivery system of transitioning to APMs and will work collaboratively to align quality and incentive metrics.

Similarly, investment in an enhanced statewide HIE infrastructure is necessary to support better data analytics and enable easy access for providers interested in participating in payment reform. The largest health information exchange (HIE) in the state (ConnectVirginia) has been able to connect many hospitals with information sharing focused on real time patient-level queries and is now planning to implement an Admission, Discharge, and Transfer (ADT) alerts system for hospitals. However, this interface has not expanded to connect physician practices and does not offer extraction software and data analytics. Much opportunity for improvement and expansion remains and investment is needed to establish the information technology (IT) infrastructure needed to support transition to APM for payers and providers in Virginia.

To date, some payers and providers, especially independent physician practices, have expressed readiness concerns and apprehension to bearing financial risk. Some areas of the Commonwealth have diverse provider capacity and robust competition, yet other areas might be served by only one hospital system. The capacity of different geographies could be problematic when transitioning to APMs, particularly if larger stakeholders are not ready or are not engaged with the change efforts.

#### **State Support and Assistance:**

Because Virginia is transitioning its remaining populations (Managed Long Term Services and Support) into managed care and re-procuring existing managed care contracts (Medallion) in 2017, Virginia Medicaid has an opportunity to leverage all MCO contracts and potentially a DSRIP program to facilitate movement towards APMs in Virginia, where plans and providers alike can transition to value centric payment structures. The state employee plan's use of Choosing Wisely and Value Based Insurance Design is also a catalytic event looking for partners to drive transformation. Active Medicare involvement in collaborative multi-payer payment reforms would provide leverage to the state's efforts and support health plan collaboration. Initial payer and provider engagement is encouraging, but Medicare participation and alignment can significantly strengthen stakeholder motivation to engage in Virginia's delivery system transformation.

The vision of a transformative environment will be enabled and empowered if a seamless data extraction/data analytics solution could be folded into a revamped HIE, and possibly combined with our All Payer Claims Database (APCD). Investment and technical assistance to establish this infrastructure is what Virginia is seeking from CMS. Movement to value-based payment will proceed slowly, if at all, in Virginia without a simplified data reporting and analytics platform to show clinicians and payers the business case for payment reform and without incentives and quality improvement

linked to combined claims and clinical quality metrics. The MACRA legislation established requirements for physicians to accept substantial financial risk starting in 2019 based on the 2017 measurement period. This will be an increasingly powerful motivator for physicians and practices to better understand performance reporting and managing financial risk. With a robust HIE and analytics solution enabling true total cost of care management and granular clinical quality improvement, the combined efforts will be an essential incentive to jumpstart willing participation across the delivery system. This would be particularly attractive if providers could report to CMS and other payers through the HIE, without having to self-generate custom electronic health record (EHR) reports for each payer.

In addition to investment and support in Virginia's HIE the Commonwealth is also seeking reasonable policy flexibility within programs such as the CPC+ or Next Generation ACO programs, in order to entice the full range of payers to agree to similar payment and quality reporting structures.

**Part 1B. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?**

Payers and providers must first agree on quality and outcomes metrics, which include patient-centered outcomes. Through the 2015 State Innovation Model (SIM) design process, the Virginia Center for Health Innovation (VCHI) led significant progress in the development of an aligned set of health system and clinical quality measures, but without the promise of SIM Testing resources, lacks the leverage to enforce adoption.

This challenge was further compounded by the fact that Medicare released its own recommended set of aligned measures within days of VCHI sharing its recommended list. While the lists are similar, important differences exist. When comparing the Virginia list with the CMS list, the following observations were made:

Table 1: High-level Differences between Virginia and CMS Measures

<b>Domains</b> and <i>subdomains</i> in the Virginia list without a significant presence on the CMS list	<b>Domains</b> and <i>subdomains</i> in the CMS list without a significant presence on the Virginia list
<ul style="list-style-type: none"> <li>• <b>Musculoskeletal</b></li> <li>• <b>Strong Start for Children</b></li> <li>• <i>COPD</i></li> <li>• <i>Mental health conditions</i></li> <li>• <i>Oral care</i></li> <li>• <i>Alcohol or substance abuse</i></li> <li>• <i>All-patient ED &amp; inpatient utilization</i></li> <li>• <i>Cost of care</i></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Gastroenterology</b></li> <li>• <b>HIV / Hep C</b></li> <li>• <b>Medical Oncology</b></li> <li>• <b>Orthopedics</b></li> <li>• <i>Surgical care and outcomes</i></li> <li>• <i>End-of-life care</i></li> </ul>

In addition to these high level differences, each measure in the Virginia portfolio was reviewed in an effort to find one or more matching measures in the CMS portfolio. The result of this analysis was a classification for each Virginia measure of “Exact match”, “Related match”, or “No match”.

While the previous domain and subdomain-level analysis was meant to identify larger thematic divergences between the Virginia and CMS portfolios, this comparison is intended to identify smaller-bore differences in specifications and opportunities for closer alignment. For example, the Virginia measures classified as “Related match” may be considered candidates for substitution with the related CMS measure.

To summarize the results: of the 78 Virginia measures (inclusive of both the “system performance” and “focused menu” measures), 13 (17%) were exact matches to CMS measures; 20 (25%) were classified as “Related match” to one or more CMS measure; and 45 (58%) were classified as “No match”.

Payers and providers must agree upon standard structure of payment and incentive models to ensure a transparent accountability mechanism for the total cost of care. The same performance metrics should adjust payment bonus/penalty across all payers and data on these metrics must be collected and submitted uniformly across participants. Existing Center for Medicare and Medicaid Innovation (CMMI) models like CPC+ and Next Generation ACOs can be the starting points and fundamental bases of these, but flexibility may be necessary to elicit cooperation from each essential payer and provider system in Virginia.

Payers and providers must also agree upon transition times and payment schedules, including the potential for essential upfront infrastructure investment at the onset of a care transformation initiative. Transitions may need to be phased-in based on realistic payer and provider needs for feasible implementation. Up-front payments would be structured to support transition to bear risk, but flexible enough to allow providers to use the payment to invest in the infrastructure needed by that practice or health system.

In addition to agreement on metrics, there must be a trusted data manager and analytics provider of the HIE and APCD. CMS funding for the creation of a data analytics infrastructure is a fundamental need for statewide delivery system reform and could catalyze the transformation process in Virginia.

Finally, additional federal support to provide timely access to Medicare data, including Medicare Advantage data, will enable Virginia to achieve multi-payer delivery system reform.

**Part 1C. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?**



As described earlier, Virginia currently has very limited APM participation and Virginia Medicaid is working to help providers see how they can thrive in a market with realigned incentives based upon data analytics. Virginia Medicaid wants to help providers first learn how to generate the data, then consider how to use the data through agreed upon analytics and measures. One key element of engaging provider participation in payment reform in Virginia is to align payment incentives across the majority of the provider's patient base. Aligning Medicare and Medicaid incentives will provide achievable scale to incent provider change. Virginia is moving towards APMs and Medicare's participation would be a catalyst to drive multi-payer alignment.

Virginia currently has a small number of regional provider affiliations; however, to achieve the level of integrated care coordination and collaboration necessary to support widespread APMs, Virginia will need broader provider partnerships. In these partnerships, providers would be working beyond their individual practice or small networks to affect better patient outcomes. Provider partnerships would work in coordination with the MCO to integrate care coordination, data, processes, and communication and provide high touch, person-centered care across the entire continuum of care. These partnerships would include medical, behavioral health, long-term services and supports providers and community-based organizations.

To facilitate these provider partnerships, Virginia needs support and funding to establish the necessary data platforms, workflows, and provider agreements.

**Part 1D. What resources and tools (e.g. funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g. to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?**

Virginia needs consistent and sustained federal financial investment in technology and infrastructure to facilitate comprehensive data exchange to achieve the patient experience, quality of care, and financial savings results sought by the Commonwealth. It is not reasonable to place increased expectations on providers to coordinate patient care more effectively, and tie their payment to their ability to provide more efficient care, without also giving them the information and tools they need to be successful in this endeavor.

Virginia needs support and investment in data exchange and analytic infrastructure. There must be a trusted data manager and analytics provider that will enable a level playing field of electronic clinical quality measure (eCQM)-driven

competition. Small practice EHRs need extraction feeds and real time dashboards of useful metrics to target areas for performance improvement. A trusted data manager will enable accurate measurement of patient care management which is only available through ubiquitous HIE participation for full patient picture (across payers and providers). A trusted data manager will also ensure trusted computation of total cost of care to reassure providers and to show payers they have vested interest in enabling this data infrastructure to continue engagement.

As part of delivery system reform, Virginia is working to better integrate behavioral health care, medical care, and long-term services and supports. Therefore, in addition to the need for better information sharing among traditional medical providers, health information exchange in Virginia also needs connections with behavioral health providers, social services, department of corrections and community-based organizations (CBOs) to capture the full data set of whole-person care. In response to the growing evidence that social factors are often the strongest driver of an individual's health outcomes, Virginia's quality metrics and data collection must include and track these social factors. This social data will support better population analytics and, most importantly, will support better interventions, care collaboration, and ultimately better health outcomes for Virginians. To collect this type of social information, Virginia needs new, bi-directional HIE connections with behavioral health providers and CBOs and new workflows from all provider types to capture social factor data. Combined social and medical data will identify best practice interventions and can help support and scale-up successful local initiatives that address social factors and improve patient outcomes.

Virginia is seeking technical assistance to determine what data is needed, how to code and track the data, and support to analyze the data. Technical assistance would include support to select standard quality measurements across payers and assistance to determine the best method to collect the data associated with these quality measures. Virginia is also seeking resources and best practice expertise to design Virginia's methodology to analyze data.

Finally, Virginia needs an expedited pathway to engage with CMMI and CMS when working to implement payer reforms, especially with Medicare participation. This would include expedited approval of State Plan Amendments, waivers and MCO contracts.

**Part 1E. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years?)**

Given Virginia's need to first establish a comprehensive data sharing platform, a reasonable performance period would be 3-5 years.



- ☐ Years 1 and 2 would focus on planning, stakeholder engagement and business agreements, system development and IT infrastructure implementation in five sites across Virginia.
- ☐ Year 3 through Year 5 would involve expansion of HIE infrastructure statewide.

**Part 1F. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?**

Virginia recommends several important prerequisites when considering meaningful state model evaluation. First, establishing outcome data specificity will ensure consistent interpretation of data elements and how they are reported for standard outcome measures. Similarly, standardizing baseline and ongoing data collection strategies will support valid and trusted data reporting. As part of the planning and design phase of delivery system reform, Virginia is exploring the data generating and gathering capacity of key stakeholders to support the degree of information exchange needed for successful APM implementation. Ensuring baseline and control group data availability requires using existing Physician Quality Reporting System (PQRS) and patient satisfaction measures, though the MIPS reporting requirements in 2017 may broaden the feasible set.

Finally, identifying appropriate control groups, either in parts of Virginia or other states would serve as an important tool in evaluating Virginia's state model to advance alternative payment methodologies.

**Part 1G. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?**

Most new Medicare APMs tie payment incentives to eQMs; however, most private sector payment models in Virginia exclusively use claims data. This is partly due to provider workflows that are not set up to capture and share quality metrics with payers and also limited health plan ability to accept and process quality outcomes from clinical data. In addition, most independent physicians have trouble generating eQMs "on demand," or in any way that differs from existing Meaningful Use or Physician Quality Reporting System (PQRS) requirements. Therefore, it will take some time and infrastructure to meld private payers and Medicare. Implementing this all-payer system will be more feasible, powerful and sustainable with a new HIE+APCD infrastructure because payers and providers will see its value.

In addition to state-level data and infrastructure considerations, CMS should take into account that state-specific all-payer models will need flexibility to accommodate the needs of populations outside Medicare as well as variations in local care environments. Population segments outside of Medicare will have different types of health needs based on age and health status. Also, there is remarkable variation in local care environments as indicated by differences in disease prevalence, medically underserved designations, local provider shortages, and socioeconomic risk factors of patient populations. States should have discretion to craft all-payer models that are

flexible enough to accommodate these variations while still adhering to the core principles of the CMS alternative payment models.

**Part 2: CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.**

**Part 2A. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment?**

Virginia is advancing towards a greater percentage of APMs across the delivery system. A primary mechanism for incentivizing better population health is through population-based payments. By organizing fully integrated and interdisciplinary provider partnerships across the Commonwealth, Virginia can hold providers accountable for health outcomes of the population they serve. Population-based payments require providers to take responsibility for patient outcomes and incentivize providers to invest in preventive services and consider additional causes for poor health outcomes. Virginia's DSRIP concept includes the formation of provider partnerships (Virginia Integrated Partners (VIPs)) to empower providers to coordinate across the full continuum of care and connect with services that address social factors affecting patient health.

Population-based payments require initial provider investment to establish the new partnerships and their information sharing capacity. These investments should be tied to provider volume and allow providers the flexibility to apply the investment where it will expedite provider engagement in population-based payment structures.

Virginia needs investment in information infrastructure, along with multi-payer incentives, to make population health top of mind for providers. With public payer support, Virginia could certainly institute payment reforms linked to population health goals, like reducing potentially preventable admissions, or increasing vaccination or prenatal care rates. As explained in response to other questions within this document, a statewide health information exchange with an analytic support function will be essential for supporting Virginia providers and plans in the evolution toward population-based payment. In addition we will need smart policies and procedures for specific functions

such as patient attribution, data sharing, performance measurement, and financial benchmarking. We have found some helpful guidance for framing these functions from the Health Care Payment Learning and Action Network's Population-Based Payment Work Group. We list the Work Group's specific recommendations for patient attribution and data sharing under Part 2C, and their recommendations for performance measurement and financial benchmarking under Part 3F.

**Part 2B. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?**

Research and experience show that social services and public health supports can be critically important for helping vulnerable populations optimize their health. As indicated in the question above, these supports can be especially important for rural and tribal populations. In ideal care environments we would see close coordination between clinical care, social services, and public health supports for defined population segments. These types of programs do exist in a variety of community settings, and many have performed well, typically with support from public or private grant funding. The challenge lies in scaling these models to work effectively in coordination with public and private health care payment models. We offer the following observations and suggestions in response to this question.

Excellent clinical care is necessary but not sufficient for helping vulnerable populations achieve optimal health outcomes. Excellent clinical care coupled with responsive social services and supportive public health can help vulnerable populations (including rural and tribal populations) manage conditions outside of the clinical setting and contribute to better health outcomes.

There are many promising practice models that can be used to inform the design of clinical-community linkages that work from a service delivery standpoint. The challenge lies in financing these models beyond the grant-funded pilot stage given the limitations of existing funding streams and the parallel complexity of managing multiple funding streams with accountability for performance.

Whatever integration models may be tried, it will be very important to avoid overlaying additional administrative complexity and financial risk on clinical providers who are already grappling with building the infrastructure needed to define and document excellent clinical care in an alternative payment model environment. Clinical providers generally see the value of having social service supports available for their patients, but they will need easy pathways to these services in order to fully embrace them.

Beyond very narrow or small-scale projects, an Administrative Services Only (ASO) model might be needed to manage multiple funding streams. ACOs and MCOs have a hypothetical incentive to invest in social services for selected Medicare and Medicaid

enrollees out of their contracted payments for these patients. However, there are administrative and accounting hurdles to be addressed, and scale becomes a factor in decisions about where and how to structure these investments. As their prospective partners, community social service agencies also have their own issues of policy, procedure, payment and scale to work out before they can engage in an integrated model.

In 2015 the Center for Health Care Strategies (CHCS) published a helpful report titled *State Payment and Financing Models to Promote Health and Social Service Integration*.<sup>[1]</sup> As the title implies, this report outlines an array of options for innovative financing, including:

- ☐ Using federal grant funds, direct state funds, or Medicaid Waiver funding to support a variety of social service supports.
- ☐ Using ASOs to manage funding at the community level.
- ☐ Using braided funding strategies to assure accountability for multiple funding streams.
- Learning from integrated service programs in such settings as Medicaid 1115 waivers in Oregon, Texas, and Vermont; and braided financing programs such as the Boston Health Care for the Homeless Program; Vermont's Support and Services at Home Program; and Minnesota's Hennepin Health Program.

[1] [http://www.chcs.org/media/Medicaid\\_-Soc-Service-Financing\\_022515\\_2\\_Final.pdf](http://www.chcs.org/media/Medicaid_-Soc-Service-Financing_022515_2_Final.pdf)

## **Part 2C. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?**

Virginia has many urban providers with overlapping catchment areas, and some that cross state lines. In responding to this question we considered our diversity of providers as well as our diversity of populations that receive care in urban areas. We also assume that the question is asked in the context of a hypothetical population-based payment model.

With this assumption in mind, we suggest that a helpful framework for defining the challenges faced by urban providers in a population-based model is provided in recent work by the *Health Care Payment Learning and Action Network's Population-Based Payment Work Group*.<sup>[1]</sup> As noted by the PBP Work Group, if providers are to assume population-based responsibility, it will be necessary to address challenges related to patient attribution, data sharing, financial benchmarking, and performance measurement.<sup>[2]</sup> From our perspective in Virginia, patient attribution and data sharing are the first priorities. We reference the PBP Work Group recommendations on financial benchmarking and performance measurement under Part 3-F.

## Patient Attribution

To determine which patients are attributed to provider groups within the population-based payment model, the PBP Work Group recommends the following steps:

1. Encourage patient choice of a primary care provider.
2. Use a claims/encounter-based approach when patient attestation is not available.
3. Define eligible providers at the beginning of the performance period.
4. Provide transparent information to patients about their attribution.
5. Prioritize primary care providers in claims/encounter-based attribution.
6. Consider subspecialty providers if no primary care encounters are evident.
7. Use a single approach for attribution for performance measurement and financial accountability.
8. Use the patient attribution guideline nationally for commercial products.
9. Align commercial, Medicare, and Medicaid populations, which may be possible with adjustments.
10. Provide clear, actionable information to providers about patients attributed to them, regardless of whether prospective or concurrent attribution is used.

## Data Sharing

Data Sharing is foundational for the success of PBP models. Stakeholders, in particular payers and providers, must commit to sharing data required to create a comprehensive picture of their patient panels. As organizations adopt PBP models, there will be an increased willingness to share data helping to forge fundamentally new relationships and actions among providers, payers, purchasers and patients. The PBP Work Group recommends the following:

1. Payers and providers should identify in advance aligned approaches and policies for data sharing to support PBP models.
2. For data to follow the patient, payers and providers should collaborate on approaches to patient identifiers that enable mapping across systems and data types (e.g., clinical, administrative, and patient-reported data). This effort should be scalable.
3. Payers, providers, purchasers, and patients should convene a multi-stakeholder group to recommend solutions that assure patients that their personal data are appropriately used.
4. Requirements for data sharing should be made explicit in agreements between purchasers and payers that participate in PBP models.
5. Payers should give patients and purchasers easy access to information on what it costs to see different providers for the same, common procedure, alongside relevant quality indicators.
6. Payers, providers, and purchasers should actively participate in pilot programs to evaluate approaches to the sharing of data across multiple payers and providers.

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[1] <https://hcp-lan.org/2016/05/pbp-models-overcoming-barriers-accelerating-adoption/>

**Part 3: Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.**

**Part 3A. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?**

Multiple years of paid claims data have been available from the voluntary Virginia All Payer Claims Database since early 2015. The Virginia APCD includes paid claims from 10 of the largest private health insurance companies as well as claims paid by the State Medicaid plan. The Virginia APCD does not currently include Medicare Fee For Service (FFS) data but Virginia Health Information (VHI), who administers the APCD on behalf of the Department of Health, is in the process of obtaining this information through the Qualified Entity application process. It also does not include data from Tri-Care, which is especially important given Virginia's large military presence. It is critical that moving forward Medicare data be provided on a timely basis. Presently, our APCD receives cleaned data from the private health insurance companies and Medicaid within 90 days of the completed quarter. But Medicare data made available to our state SIM lead, VCHI, is received 10 months after the close of the calendar year. Additionally, some claims paid by private Medicare Advantage plans are included in Virginia's APCD, but the data for this population is not comprehensive.

**Part 3B. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcomes measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?**

The Virginia APCD includes the data necessary to calculate quality and population health measures for the Medicaid, commercial and soon Medicare populations. The Virginia APCD does not include information on social service or housing information and state law prohibits the linking of APCD data with any other data source. This will need to be addressed.

Virginia needs better access to timely data via statewide HIE with ubiquitous participation. An important challenge facing Virginia's delivery system today is an inability to overlay claims and clinical data. Marriage of claims and clinical data through this statewide HIE will strengthen care coordination opportunities, improve population health interventions and facilitate predictive data analytics to best allocate



resources. Today, clinical data is held at the provider level and claims information is held by payers. Combining clinical and claims data will require expansive HIE connection that includes all payers, all major Virginia health systems, individual provider practices, behavioral health providers, and community-based organizations.

Part of the effort to better calculate quality and population health measures from the collected data includes work to select and standardize specific quality metrics and identify required data for payers and providers to collect, which includes data related to the social determinants of health. Also of import is for data to be collected from payers and providers in a uniform way and adequate staff to conduct these analyses.

One challenge of collecting data is verifying the data are clean and reliable. To verify data is clean and reliable, Virginia needs technical support to: select required data elements; mechanize and integrate data; develop a centralized hub through which to collect data; analyze collected data.

At the provider level, Virginia needs capacity building to help providers optimize their electronic health record systems for quality measurement and population health management. Although there is plentiful data within these systems, many providers are unable to glean valuable clinical intelligence from this data because of one or more of the following:

- Design flaws within the record system,
- Lack of time or technical capacity to design and produce relevant reports from the record system,
- Scattershot reporting requirements that overwhelm capacity and leave little or no time for designing and reflecting on clinical intelligence that really matters.

These fundamental challenges are significant and not unique to Virginia. To achieve clinical excellence within an alternative payment model environment, providers need and deserve to focus on clinical measures that really matter, with electronic health record systems that are up to the task, and technical support for analytics that will streamline quality measurement and reporting, and allow providers to focus their time and energy on excellent clinical care.

Taking a broader look at the idea of combining clinical and non-clinical data to inform patient care, the vision is laudable, and a growing list of examples can be found in the literature as well as the CMS innovation portfolio.[1] At this stage innovation in this area is promising but localized. Next-level challenges include spreading the use of social service data into standard practice; incorporating social service data into HIE; and aligning payment and risk adjustment to support clinical-social models. Before addressing these aspirations, however, it will be critically important to help clinical providers solve their challenges with managing and analyzing the clinical data they already have.

[1] See for example <https://innovation.cms.gov/initiatives/health-care-innovation-awards/mississippi.html>

**Part 3C. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?**

Virginia has an established process to share de-identified APCD data from FFS private Medicaid Managed Care Plans with CMS via a data use agreement signed between CMS and Virginia Health Information.

Additionally, Virginia has positioned itself as a leader in the Medicaid arena by being one of the first state Medicaid agencies to participate in T-MSIS. Virginia was one of a handful of states to perform Beta Testing of T-MSIS version 2.0. To maximize both participation in and benefit from T-MSIS, Virginia is currently focusing its efforts on outgoing data sharing of Medicaid data.

Virginia has some foundational resources in place for harnessing the full potential of the data at its disposal, including data from T-MSIS, to provide a better data system for all stakeholders. Having a global view of Medicaid through a solution like T-MSIS is anticipated to add considerable value to Virginia.

**Part 3D. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?**

Virginia has recently enhanced its investment in analytics and outcomes measurement by expanding its Medicaid analytics platform and forming an Office of Data Analytics with staff dedicated to data warehousing and analytics. As part of this new effort, Virginia Medicaid is selecting a vendor to facilitate a new data warehouse, and also contracts with other experts, like PriceWaterhouseCoopers (PWC) for cost analytics and other technical support. In addition, Virginia Medicaid has augmented staff capacity by forming the Office of Innovation and Strategy to focus on delivery system reform and related projects. The agency has also recruited health economists and other specialized policy staff to support Medicaid's participation as a primary partner in Virginia's effort to build critical IT infrastructure and connect payers and providers through statewide HIE.

While Virginia Medicaid has made significant strides in expanding the data analytics and staff capacity necessary to implement value-based payment reforms, the agency would benefit from CMS technical assistance and perspective when building and implementing value-based payment arrangements, including benchmark development, operationalizing the linkage of quality and outcomes to performance and payment including shared savings mechanisms. Virginia also stands to learn from the efforts and lessons other states have encountered when planning, designing, implementing, and evaluating alternative payment models. Sharing the expertise and tools developed



during such efforts would be a benefit as Virginia Medicaid seeks to advance its value-based payment efforts.

### **Part 3E. What support can CMS provide to improve states' access to reliable and timely data?**

There are several means of support that could be provided by CMS to improve access to reliable and timely data. Currently there are two distinctly different methods to obtain Medicare FFS data for private organizations and state agencies, the CMS Qualified Entity Program and the State Research Request. Having one application and authentication process to request data on behalf of both types of organizations would ease the administrative burden necessary to request CMS data. CMS could also authorize and direct Virginia Medicare Advantage plans to submit data to the Virginia APCD. CMS could provide insights around facilitating SUD data sharing in new delivery models. Finally, having the necessary funding available to support statewide initiatives utilizing multi-payer claims data is critical.

### **Part 3F. How can CMS support improve access to and linkage with health outcomes measures data?**

A fundamental principle for CMS to consider is that health outcomes measures data should be presented in ways that inform clinical practice in the context of the operative payment model and the population segment. To illustrate, if the operative model is bundled payment, it is most helpful to view outcome data in terms of benchmarks for bundled payment for specific care models within logically defined population segments. This same principle applies if the operative payment model is episode-based, condition-based, or population-based. This type of information could be very helpful for clinical providers seeking to learn where they stand and how they might improve within an alternative payment environment.

With this idea in mind, we again reference recent work by the *Health Care Payment Learning and Action Network's Population-Based Payment Work Group*.<sup>[1]</sup> As noted by the PBP Work Group, if providers are to assume population-based responsibility, it will be necessary to address challenges related to financial benchmarking, and performance measurement as outlined below.<sup>[2]</sup> Although these recommendations are focused on population-based payment models, the core principles apply to multiple types of alternative payment models.

#### **Performance Measurement**

Performance Measurement is grounded in the notion that payers, providers, purchasers, and patients should be collectively accountable for ensuring that the health care system delivers the highest possible value. To that end, the PBP Work Group recommends the following:

1. Support long-term success and sustainability of PBP models with new measures where results matter to patients.

2. Avoid fragmentation across PBP models using existing core measure sets while continuing innovation and refinement to create and establish comprehensive, affordable, and outcomes oriented core measure sets.
3. A governance process to oversee and accelerate the development, testing, and use of new, high priority measures for PBP models.
4. In service of a future state that employs measures that are outcomes-oriented, the infrastructure nationally must be sufficient to systematically collect, use, and report clinically rich and patient-reported data.
5. Providers in PBP models should have meaningful incentives to deliver high-quality care, achieve favorable outcomes, and manage the total cost of care.
6. Define performance targets in a way that motivates ongoing improvement across the performance continuum, promotes best practice sharing, avoids a forced curve that mandates winners and losers, and enables long-term planning and commitment to improvement.
7. Adhere to good measurement science and implementation in order to achieve the desired performance measurement results from PBP models.

### Financial Benchmarking

The PBP Work Group also provides recommendations for financial benchmarking as follows:

1. **Establish and Update the Financial Benchmark.** Approaches to financial benchmarking should encourage participation in the early years of the model's progression, while driving convergence across providers at different starting points toward efficiency in the latter years.
2. **Risk Adjust Regional and National Benchmarks.** Risk adjustment must strike a balance between avoiding unduly penalizing providers serving higher-risk or disadvantaged populations, and avoiding substandard care of these populations.

[1] <https://hcp-lan.org/2016/05/pbp-models-overcoming-barriers-accelerating-adoption/>

### Part 3G. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?

Virginia's contract monitoring teams and Program Integrity Division oversee quality and compliance monitoring for Medicaid service delivery using the following data sources: fee-for-service claims, encounters, eligibility and benefits data, recipient demographic data, provider data, and financial data. In addition to Medicaid data, Virginia also receives Medicare data for the dually-eligible population. In addition to quantitative program evaluation, Virginia Medicaid employs several qualitative program evaluation strategies. For example, in Virginia's Financial Alignment Demonstration, the Virginia Medicaid contract monitoring team engages health plans through regular verbal review of quantitative data through a quality metrics dashboard, but also conducts face-to-face observations of program activities, interviews with providers, and facilitated a telephone survey of enrollee satisfaction with the program. Virginia has worked collaboratively with CMS through the Financial Alignment Demonstration to streamline and improve bi-directional data sharing between Virginia Medicaid and CMS.

Virginia is taking advantage of a key opportunity to advance compliance and program integrity methods by building new requirements into managed care contracts. Through these contracts, Virginia Medicaid will require additional data sharing with more specific time requirements from contracted plans. The Medicaid agency is currently building new functions and capabilities to accept the additional MCO data.

Claims that are submitted to the Virginia APCD are subject to over 100 data quality validations. VHI works extensively with all health plans that participate in the Virginia APCD to ensure the data collected is as accurate as possible.

**Part 3H. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?**

One key challenge to payment reform in Virginia is the decentralized nature of health information. Virginia's existing IT infrastructure is maintained separately at the provider and payer levels. Providers hold key clinical information and data about patient quality outcomes. Payers maintain data about service authorizations and claims. To realize delivery system transformation, Virginia needs a repository of secure clinical and claims information.

Comprehensive enrollee information would facilitate better analysis of factors that are driving costs and better understanding of factors contributing to the highest health care utilization and cost. Combining clinical information with existing billing information would create better risk stratification across populations and enable APM incentive alignments. One consistent theme that emerges from successful delivery system and payment reform efforts in other states is that access to patient clinical information in real time (at the time of the clinical event) is an absolutely critical component for provider buy-in to quality improvement. Real time access to this data would enable payers and providers to immediately engage patients in programs designed to address individual needs. Having the complete picture of each patient's health information would facilitate continuity of care for Medicaid patients who move between Medicaid coverage, private coverage, and no coverage at all. A centralized platform also provides strong data governance to ensure reliability and standardization of this clinically actionable data.

Virginia is seeking investment and technical assistance to establish a centralized health information exchange and repository of health information to facilitate more robust analytics and better care coordination. Virginia would particularly benefit from support from CMS and alignment with Medicare data to drive multi-payer engagement in Virginia.

## Section II: Assess the impact of specific care interventions across multiple states

**Part 1: CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).**

In the coming years, the Virginia Medicaid program will become an increasingly effective platform for testing standardized care interventions across the state. Virginia's long history of furnishing Medicaid coverage through managed care, coupled with the continued phase-in of new populations in 2017 and 2018 means the overwhelming majority of the state's Medicaid population will soon be covered under managed care. As such, the state is well positioned to implement care interventions that require uniformity of design, measurement, and evaluation across regions and Medicaid patient populations through alignment of contract language and requirements, and collaboration with a defined group of payers.

This potential for aligned incentives and close payer collaboration puts Virginia in a unique position to deliver on delivery system transformation goals, such as those required under state DSRIP programs. In addition Virginia Medicaid is procuring long-term services and supports and the Medallion programs which include the majority of the population. These new managed care contracts are a platform to align incentives and standardize care. Not only does this alignment facilitate uniform incentives and goals, but also allows Virginia Medicaid to introduce certain standards of care that would be required in provider agreements, including agreements to participate in pilots with funding support and oversight by Medicaid and its contractors.

Currently Virginia Medicaid is exploring requiring an evidence-based care transitions model, such as the Coleman CTP® model, within its contracts with providers. Currently, care transitions is broadly interpreted. There is no standardized approach. Some MCOs make a telephonic contact or use the required 30-day Care Management visit as the "care transition" even though it may be weeks after the hospital discharge and contains no elements of care transitions. Further, if emphasis were placed on using CBOs, there would be an increase in addressing "Social Determinants" without establishing new funding streams.

**Part 2: Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?**

We believe that Virginia providers would be willing to consider standardizing care interventions to align with other states, such as the CMS CCTP demonstration, if certain parameters were in place. For example, the intervention would have to include:

- ☐ A clearly defined population;
- ☐ A clearly defined, evidence-based intervention model;
- ☐ Clinically appropriate flexibility to adopt the intervention model to meet the needs of special populations;
- ☐ Clear guidance on payment model parameters;
- ☐ Access to performance data from participants in a format appropriate to support learning;
- ☐ Sufficient technical assistance to make the initiative feasible without compromising provider productivity.

The question of lead time is important, and the answer could vary based on the population (e.g. Medicare, Medicaid) and the type of care intervention to be evaluated. This being said, the Virginia Department of Medical Assistance Services is actively engaged in collaborative innovation with its contracted health plans and providers, and would be willing to explore innovation pathways that serve the best interests of Medicaid enrollees. The involvement of academic institutions or other research experts would again depend on the population and the intervention model, but we feel that these partnerships would strengthen data integrity. Virginia has a track record of collaborative innovation with these entities.

**Part 3: Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.**

The Coleman CTP® evidence-based care transitions model, successful with Medicare patients in Virginia, should be tested with the Medicaid population, ACOs and physicians groups for prevention of unnecessary Emergency Department visits and hospitalizations. Additionally, an evidence-based behavioral health intervention such as Baylor University's Healthy IDEAS, which targets depression and anxiety, and an evidence-based Substance Abuse intervention should be tested with the Medicaid population as these issues are more prevalent in Medicaid, than in Medicare, populations. These are cost-effective and in evidence-based testing proven to be

outcome-effective. Our own Virginia-based Eastern Virginia Care Transitions Partnership had data demonstrating a reduction of readmissions from an average of 25% to 13% with CTP and even greater reductions when Healthy IDEAS was utilized.

**Part 4: CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.**

A key product of the Virginia SIM Design Grant was our inaugural *Virginia Plan for Well-Being*. [1] Reducing health disparities is a cross-cutting priority for all of the recommendations within this plan. Also, Virginia has established an Office of Health Equity within the Virginia Department of Health. The mission of this office is to identify health inequities and their root causes and promote equitable opportunities to be healthy. The defined priorities for the Office of Health Equity are as follows:

1. Analyze data to characterize inequities in health and healthcare, their geographic distribution (e.g. neighborhood, rural, inner city), and their association with social determinants of health; and identify high priority target areas.
2. Promote equitable access to quality health care and providers.
3. Empower communities to promote health equity.
4. Influence health, healthcare, and public policy in order to promote health equity ("health equity in all policies").
5. Enhance the capacity of public health and our partners to promote health equity.

This focus on health equity has always been critically important. Health equity also takes on a new dimension of importance in the context of health care value. If alternative payment models create new types of incentives for producing measurable improvements in health and health care, then alternative payment models also create new types of incentives for closing health equity gaps without unduly penalizing providers that serve vulnerable populations.

As we learn more about the social determinants of health it becomes clear that addressing obstacles to access and gaps in community supports are essential for achieving clinical targets for excellence. We also know that health equity is a shared responsibility that cannot be solved by the health care sector or any single sector by itself. This reality underlies the *Virginia Plan for Well Being* and its core aims for healthy, connected communities; a strong start for children; preventive actions; and effective systems of health care. The implication is that Virginia and other states need to think creatively about leveraging their roles as policy makers, purchasers, partners, and program providers to promote health.

This work of advancing health equity can be applied through state actions in health care purchasing, as well as policy and programming in public health, education, social services, transportation, housing, community development, economic development, and



other supports that promote population and community health. Focusing very specifically on health care, we can improve access to care through Medicaid expansion and addressing service gaps in medically underserved areas. We can also optimize quality by pursuing the types of infrastructure development, care model innovation, and payment innovation outlined throughout this document. Ideally we can support these efforts by leverage social services and other community services to help our more vulnerable populations achieve better health outcomes through excellent clinical care coupled with effective community supports (while considering the opportunities and challenges of this approach as previously outlined in Part 2B).

[1] <http://www.vahealthinnovation.org/wp-content/uploads/2016/01/Plan-for-WellBeing-DRAFT.pdf>

### **Section III: StreamlinedFederal/StateInteraction**

**Part 1: CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?**

Virginia is engaged in the state-led transformation efforts both in partnership with the Virginia Center for Health Innovation and through state-supported transformation efforts. While Virginia has gained traction in design efforts through SIM Round 2 and Virginia's DSRIP waiver application there is much opportunity to accelerate the payment reform efforts.

Virginia needs strong Medicare-Medicaid partnership in designing multi-payer strategies to transition providers to advanced APMs. State participation in design ensures consideration of state-led payment reform efforts and enables bidirectional communication about state and federal needs.

Virginia has had successful pilots, such as the Eastern Virginia Care Transitions Partnership (EVTCP), and with sustained federal support Virginia could realize significant benefits across the state. While Virginia may not be an early adopter in the payment reform efforts, Virginia recognizes the value of being a smart replicator.

Virginia Medicaid has commented on CMS/HHS rulemaking or requests for information either independently or in partnership with the National Association of Medicaid Directors.

## **Part 2: How can CMS/HHS better align in order to support state delivery system reform efforts?**

CMS/HHS can continue to provide leadership in the development of aligned clinical quality and population health metrics for the country. It is very difficult for a state to convince a national health plan or health system to make state specific concessions on measurement, unless that state has significant payment leverage. We need CMS/HHS to be aligned with Virginia in the pursuit of shared metrics.

Additionally, we need CMS/HHS/ONC to continue to exert influence on the EHR vendors to develop and upgrade their products so that providers can review their quality performance and make actionable adjustments in real time. This is essential for both MIPS and APMs, and is much more than is currently required to meet meaningful use certification standards.

CMS/HHS can align with the goal of health equity by developing payment models that provide positive incentives for serving vulnerable populations. Within Virginia and other states there are large numbers of Medicare and Medicaid patients who are especially vulnerable due to social determinants of health and complex health conditions. There is a risk that providers who serve these patients will be financially penalized by alternative payment models in the absence of risk adjustment methods that account for patient vulnerability. We realize that such risk adjustment methods are in their infancy and more testing is needed. But if the wave of payment reform proceeds without specific attention to these populations we run the risk of creating a system that would exacerbate health disparities rather than promote health equity.



October 26, 2016

Centers for Medicare & Medicaid Services  
US. Department of Health & Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Sir/Madame:

Request for Information on State Innovation Model Concepts

I am pleased to provide comments on the Center for Medicare and Medicaid Innovation (CMMI) Request for Information (RFI) on State Innovation Model (SIM) Concepts.

The Milbank Memorial Fund (the Fund) is a nonpartisan health foundation committed to improving population health by connecting leaders and decision makers with the best evidence and experience on key health policy topics. In particular, we provide opportunities for state health policymakers to collaborate and share information with the goal of developing or applying evidence to address emerging policy challenges.

In that context, we welcome the opportunity to provide comments on expanded or new concepts for state innovation models as described in the RFI. The specific experiences the Fund brings to this topic are three-fold:

1. Facilitation of the Multi-State Collaborative for multi-payer primary care transformation since 2009 that focuses on coordination of payment reform across multiple payers;
2. Our work with states to measure total cost of care and set limits on health care cost growth; and
3. Identification of key health policy priorities through the nonpartisan Reforming States Group, a by-product of which is the commissioning of evidence-based reports on specific topics.

The Fund does not speak for any specific states in relation to their participation in these projects, but we can summarize key points of their experience in response to the questions posed in the RFI. In general, we can say that:

- There is continuing strong interest among the states to build on current innovation models and to test new concepts that advance population health improvement through multi-payer, multi-sector collaboration.
- To successfully take on these challenges, states will need continuing policy and funding support from CMS. This could take various forms including expansion of SIM or other mechanisms to leverage Medicare's payment reform resources.

### **Comments on Specific SIM RFI Categories**

#### **SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

You have requested comments on concepts for a potential future state-based model to implement broad-scale, multi-payer delivery and payment reforms to help providers participate in advanced Alternative Payment Models (APMs). Implicit in this question is a refocusing of CMS's efforts to promote state health innovation models based on the broad goal of adoption of APMs, consistent with the vision and goals set forth by the HHS Secretary. We think this refocusing is appropriate and needed.

The RFI identifies two potential pathways that states could pursue:

- A state-specific, multi-payer model that includes Medicare, Medicaid, CHIP, and commercial insurers, or
- A state-based model that aligns Medicaid and private-payer participation in an existing Medicare model [e.g., Medicare Shared Savings Program (MSSP) or Comprehensive Primary Care Plus (CPC+)].

**Section I, Questions 1 (a)-(c):** The RFI asks about the challenges and factors for success in developing multi-payer alignment around APMs and delivery system reform. Based on our experience, both of the pathways described in the RFI are viable, and it may be desirable to give states a choice, rather than limit future options to one or the other, because they offer specific opportunities and challenges.

The state-specific model requires states to commit to comprehensive reform strategies engaging their health care stakeholders and the public. This model would result in very broad changes within a state, but it is also likely to be limited to a very small number of states that can undertake this level of commitment. For example, Vermont and Maryland are two of the states participating in the Fund's Multi-State Collaborative and the total cost of care project. They are leveraging existing Medicare models (MSSP and Next Gen ACO), but each has adapted specific strategies tailored to their local issues. Both states started with regulation of hospital costs, and have leveraged SIM and CMS waivers to enhance Medicare's role as an essential partner to control total costs.

On the other hand, the Medicare-state alignment model could be implemented in a larger number of states. Many states have sponsored or participated in multi-payer primary care payment reform initiatives. Federal policies will accelerate Medicare value-based payment. We believe there is an untapped opportunity in speeding adoption of APMs through greater and more explicit alignment of state Medicaid payment reform efforts with Medicare payment reforms. In local markets, this could result in 60% or more of the payments to certain providers being essentially aligned, and greatly enhance prospects for delivery system reform and ultimately significant performance improvements.

**Section I, Question 1 (d):** The RFI asks for feedback on the resources, tools, and other types of assistance that would be helpful to support state-based alignment with Medicare and other payers. From our work with the Multi-State Collaborative and the states working on total cost of care measures, we know that these initiatives are very complex and require dedicated resources to perform myriad key functions—stakeholder convening, education, and outreach; developing consensus on all-payer or multi-payer standards; collecting, aggregating, and analyzing claims and clinical data to manage and monitor population health, just to name a few. Many state Medicaid agencies have also made significant commitments to managed care financing strategies. Learning how to accomplish and oversee contractor payment reform implementation is a new skill for these agencies.

Successful programs for multi-payer payment reform have already demonstrated that long-term investment is required, and Medicare and Medicaid should be meaningful partners to sustain that work. CMS needs to provide ongoing funding support for states to build administrative capacity to design and implement multi-payer programs. Short-term grant funding is helpful, but it is not sufficient. There should be mechanisms for ongoing Medicare and Medicaid administrative funding to build capacity for this purpose.

- Medicare is providing more data to states to support innovation models, but states still need resources to work with the data and translate it into meaningful information.
- States should have a clear path to draw down Medicaid administrative funds to support design and implementation of multi-payer models that will include Medicaid beneficiaries, similar to what Vermont has done.
- Waiver programs also need to account for the significant infrastructure investment needed to support health care transformation operations.

**Section I, Questions 1 (f) and (g):** A final challenge common to CMS and states is to find the right balance between national standardization in payment reform models and local variation that takes into account environmental factors and the need to learn what works. That balance is elusive and may require stronger direction and guidance from the federal government, particularly as a significant financier of Medicaid. Perhaps the availability of any funds for the Medicaid capacity building requested here could be conditioned on Medicaid agency alignment with one or more existing Medicare payment innovations. With this approach, the dual goals of spurring innovation while supporting meaningful evaluation could both be addressed.

**Section I, Question 3:** The RFI asks how CMS can help states get access to reliable and timely data. We think there are two components to this question:

1. Claims data is an essential component to design, administer, and evaluate multi-payer payment reform. There are a variety of approaches, including state all-payer claims databases and claims databases created by private sector groups (national and regional). CMS should ensure that regardless of who organizes the data, there is enough transparency to ensure that stakeholders trust the source and have a common view of data to answer key questions.

2. Providers need access to reliable and timely clinical and administrative data to coordinate and manage care, which in turn supports their ability to achieve performance levels for enhanced payment. Again, there are a variety of approaches including state and regional health information exchanges or specific health information technology-enabled services (e.g., emergency department admission alerts). As with claims data, CMS should ensure that stakeholders consider the state's chosen mechanism to be trusted and reliable. CMS should work with other federal agencies to further demystify policies governing data use, particularly as they relate to treatment of substance use disorders and mental health.

## **SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES**

Adoption of APMs alone will not be sufficient to improve population health, particularly for high cost/high need Medicaid populations. Future state innovation models could provide a testing ground for delivery and payment models that explicitly address social determinants of health. The Fund has collected evidence in support of investments in social services that complement or even transcend a traditional health care model. We have also prepared a practical [guide](#) explaining how Medicaid covers these services today.

A new SIM care intervention design could allow states to demonstrate cost savings and improved outcomes with the certain social services included as covered benefits in the context of a broad, multi-payer approach. As with payment reform, states need a clear path for Medicare and Medicaid participation in these new models. Most primary care and ACO models have not extended very far beyond traditional health care services, so it is timely to encourage development of new delivery and payment models that extend to social determinants and outcomes. Here are our most recent reports on [behavioral health integration](#) and [social services supports](#).

## **SECTION III: STREAMLINED FEDERAL/STATE INTERACTION**

The RFI asks for suggestions regarding ways to improve the federal-state partnership to support delivery and payment reform alignment. CMS has established a focal point for innovation policy and communications through CMML. We offer three suggestions to strengthen this model:

1. It is important for CMML to coordinate with the regular operating components of CMS and other federal agencies. States need policy approval from both Medicare and Medicaid to operate these programs. It would be greatly beneficial to state policymakers if Medicare, Medicaid, and CMML spoke with one voice to states about APM adoption in policymaking and policy development. Similarly, states need a way for their proposals, applications, and requests for policy interpretations by CMS to be addressed in a consistent, coordinated, and expedited fashion.

2. In addition, many policies and funding streams that contribute to states' overall health and health care ecosystem are operated by other HHS components. Multi-payer alignment for delivery and payment reform can be an effective strategy, but we imagine it would be even more effective if the federal and state governments had a mechanism to look at all health-related investments to fully leverage these resources and ensure that the incentives are really aligned. For example, HRSA has a significant role overseeing funds for FQHCs and GME—these funding streams could play important complementary roles in states' funding alignment strategies.
3. Just as states need to devote significant resources to develop and implement innovation models, the federal government needs to invest in its own administrative requirements. CMS has provided important strategic direction. However, we know that strategy is not enough—the facilitation and convening roles are absolutely essential to advance multi-payer initiatives, as has been observed in MAPCP and CPC. Dedicated federal and state resources should be devoted through a collaborative model to the care and feeding of these programs at the ground level.

## CONCLUSION

We greatly welcome CMS' initiative to seek comments on concepts for state-based payment and delivery system reform initiatives. As noted, CMS is currently a significant partner assisting states with innovation models through Medicaid and broader, multi-payer efforts. This is a strong foundation upon which to build, and now we have the opportunity to dramatically enhance the impact of these programs.

In our comments on the RFI, the Fund supports CMS partnering with states to accelerate and broaden adoption of Medicare APM models. We also suggest development of a standardized care intervention package that focuses on social determinants of health, utilizing policy levers to expand integrated care models beyond the health care system. Finally, we recommend that CMS further develop and coordinate its policymaking capacity, and provide funds to states for capacity building in order to most effectively manage the process of health care transformation.

Thank you for the opportunity to comment. The Fund would be pleased to answer any questions raised by this response and provide additional comments as you consider future options.

Sincerely



Christopher F. Koller  
President  
Milbank Memorial Fund



CFPC, 505 5<sup>th</sup> St., Suite 404  
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October 24, 2016

Patrick Conway, MD, MSc, FAAP  
Deputy Administrator, Center for Medicare and Medicaid Innovation  
Chief Medical Officer, Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Dr. Conway:

Both through its State Innovation Model (SIM) grants to states and through Federal Opportunity Announcements, the Center for Medicare and Medicaid Innovation has advanced thinking and innovation on health services and financing to achieve the “triple aim” of improved health quality, greater population health, and reduced per capita health care costs. CMMI has served as a catalyst to state and community actions to develop new practice models and incorporate them into Medicaid financing, both with dual eligible populations and with those only covered under Medicaid.

At the same time, with very few exceptions the focus has been on chronic care populations that are current or soon-to-be high-cost users of health services – with expectations that there will be significant reductions in per capita health care costs among the populations served within at most three years.

As a result, there has been very little in CMMI’s work to date that has advanced community or state action to transform health care services and financing for children who do not have chronic health conditions – e.g. that focus upon improving primary, preventive, and developmental health services to achieve the triple aim.

One recommendation related to the next round of SIM grants is that a share of the funding provided to states in both planning and testing phases be specifically devoted to the pediatric population and the provision of primary health services. Children currently compose nearly half of state Medicaid (and CHIP) populations and twenty percent of Medicaid expenses. CMMI could require that at least one-fifth of all time and expenditures under SIM grants be devoted to that population of children who are not currently dual eligible or otherwise having chronic health care needs – and that any examination of the

impact on per capita health costs be based upon dynamic scoring and life course impacts. <sup>i</sup> This would begin to address what the American Academy of Pediatrics has emphasized in its own letter to CMMI regarding SIM grants:

The Academy urges CMMI to consider the unique needs of pediatric populations and identify payment models that reflect the unique emphasis on prevention and healthy growth and development that is the foundation [of] primary pediatric care. **Only by designing a payment system with children in mind at the beginning will the healthcare system produce quality care, improved outcomes and lower cost** (emphasis added). <sup>ii</sup>

Fortunately, while most state Medicaid systems have yet to develop such financing systems, CMMI does not need to start from scratch in promoting such actions.

First, there is a growing and compelling literature on the foundational importance of the first three years of life in achieving lifelong health. States and their policy makers increasingly are recognizing this importance and seeking to develop policies to respond more preventively in those first years. <sup>iii</sup>

Second, there is a growing array of evidenced-based primary child health care practice models which have demonstrated their efficacy in elevating health trajectories in these years. <sup>iv</sup> While currently primarily funded through foundation grants or other funds and not through health coverage, these models are seeking out ways to become incorporated into sustainable health care funding streams, particularly Medicaid, and can provide real-world insights into doing so. <sup>v</sup>

Third, if these were to become a standard of care within primary practice covered by Medicaid, there is no doubt that they would dramatically improve population health over the life course, improve the quality of care, and reduce the presence of chronic health conditions and morbidities that contribute so greatly to health costs. They are positioned to contribute greatly to achieving the triple aim. <sup>vi</sup>

Fourth, the federal government, within the Affordable Care Act, specifically has recognized *Bright Futures* as the standard of care for providing primary care, which aligns very well with these emerging models. The next iteration of *Bright Futures* will place increasing emphasis upon primary child health practices in responding more preventively, developmentally, and ecologically in ways designed to improve child health at a population level. <sup>vii</sup>

Through both its next iteration of SIM grants and its continued development of Federal Opportunity Announcements, CMMI has the opportunity to refocus attention and innovation on what is most critical to improving population health over the life course – the development of elevated health trajectories for children, and young children in particular, in their families and communities.

Sincerely,

/s/ Charles Bruner, Co-Principal Investigator, Learning Collaborative on Health Equity and Young Children, [cbruner@cfpciowa.org](mailto:cbruner@cfpciowa.org)

<sup>i</sup> In Iowa, the Child and Family Policy Center, the Child Health Specialty Clinics, and other child health groups were active in the SIM planning process in advocating for attention to the young child pediatric population and focusing upon social as well as bio-medical determinants of health, attending all planning meetings and providing substantial feedback and testimony. While Iowa Medicaid Enterprise was very appreciative of this input, the contractor for the planning process had almost no special expertise on child health issues and – despite the

advocacy provided – the Iowa SIM testing grant did not incorporate any of the recommendations made for a specific focus of some of the testing dollars on children’s health and healthy development. Without specific direction from CMMI regarding child health, it is difficult for states to carve out resources to focus upon this current low-health-cost child population.

<sup>ii</sup> American Academy of Pediatrics letter to Patrick Conway, October 19, 2016. /s/ Bernard Dreyer, President.

<sup>iii</sup> We refer to these as the P.A.R.E.N.T.S. Science (Protective factors, Adverse childhood experiences, Resiliency, Epigenetics, Neurobiology, Toxic stress, and Social determinants of health), because the actual literature from these diverse fields of study all points to the primacy of improving the safety, stability, and nurturing in the home environment as key to children’s healthy development from birth to three. References to these literatures are extensive—the Center for the Study of Social Policy has a good summary of the protective factors literature under

its Strengthening Families work; the Center for Disease Control and Prevention has led in the work around Adverse Childhood Experiences; the Center for the Developing Child has defined and makes use of the term ‘toxic stress’ to emphasize early child-development, and Healthy People 2020 (as well as the CDC) has emphasized addressing social determinants of health within primary and preventive health practice.

<sup>iv</sup> For an overall policy framework and enumeration of select program models by some of the recognized pediatric child health policy leaders, see: Bruner C, Dworkin P, Fein A, Hayes M, Johnson K, Sauia A, Schor E, & Shaw J (2016). *Transforming Young Child Health Care Primary Practice: Building on Evidence and Innovation*. Des Moines, IA: Learning Collaborative on Health Equity and Young Children. The appendices show how this fits into other thinking regarding needed transformations in primary care to achieve the triple aim, including excerpts from the seminal article from *Health Affairs* on the triple aim.

<sup>v</sup> Bruner C & Johnson K (2016). *Young Child Primary Pediatric Practice Transformation: Medicaid Financing to Improve Child Health and Development*. Des Moines, IA: Learning Collaborative on Health Equity and Young Children. The appendix includes an excerpt from a Baillet Health report which describes the particular challenges to current accountable care and managed care reform effects responding to such preventive services and how definitions of “value-based care” need to be restructured if they are to do so.

<sup>vi</sup> While there have not been longitudinal research studies spanning decades that could demonstrate long-term fiscal impacts (returns-on-investment or rates-of-return) for exemplary program models (such as do exist with respect to a handful of early childhood/preschool programs), there are demonstrated gains from exemplary program models with immediate impacts upon both social determinants and child developmental trajectories which are equally if not more pronounced than those produced by those early childhood/preschool programs. These can be imputed to have long-term impacts upon morbidities and chronic conditions that have profound costs. One of the values of CMMI attention to these areas could be building the capacity to do such actuarial analyses and for states to look beyond immediate impacts to longer term gains. In fact, this is key to making “value-based care” a reality within Medicaid financing systems as it relates to the pediatric population.

<sup>vii</sup> In Section 2713 of the Affordable Care Act, the federal government established a group health plan and health insurer mandate that coverage provide, with no cost sharing requirements, certain preventive services. These preventive services “with respect to infants, children, and adolescents” include “evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration,” e.g. *Bright Futures*. While the Affordable Care Act not only effectively made *Bright Futures* the standard for practice and included a number of other provisions designed to promote preventive care and population health, in most instances federal implementation actions have done little to promote more than a periodicity schedule for primary care based upon *Bright Futures* for children covered under Medicaid and CHIP who do not have existing chronic conditions. For an enumeration of the different provisions in the ACA that might speak to these issues, see: Bruner C, Fitzgerald C & Berg A (2010). *Federal Health Reform and Children’s Healthy Development: Opportunities for State and Community Advocacy and Foundation Action*. BUILD Initiative; and Bruner C & Fine A (2010). *Going Beyond Coverage to Improve Community Health*. Health Reform Implementation: Opportunities for Place-Based Action Issue Brief 1: Center for the Study of Social Policy.



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**Office of the President and CEO**

October 27, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Mr. Slavitt:

### **Re que st For Information on State Innovation Mode ls Concepts**

The State Innovation Models (SIM) initiative is critically important to states as they work to transform health and health care systems and strive to catalyze measurably better health outcomes for their citizens. The progress that states have achieved under the SIM initiative are commendable. States continue to be laboratories for testing various innovations for improving delivery and payment models and for promoting population health. We are particularly heartened by the diversity of states that have sought to leverage the opportunities available under the SIM initiative, which includes 35 states and the District of Columbia. As such, the Robert Wood Johnson Foundation (RWJF) believes the SIM initiative has played a central role in helping to build a Culture of Health in the United States, where everyone can be as healthy as possible. We appreciate the opportunity to respond to this Request for Information (RFI) and would like to recognize input from various Foundation grantees in generating these comments including: The Center for Healthcare Strategies, State Health, and Value Strategies at Princeton University, the National Academy for State Health Policy, the University of Colorado Farley Center, Health Leads, Bailit Health, the YMCA of the USA, Arizona State University Safety Net Action Center, the National Governor's Association (NGA), the National Network of Public Health Institutes, and Catalyst for Payment Reform. While these organizations each provided input to this response, these comments represent the views of the Robert Wood Johnson Foundation and not necessarily those of these or other grantees. These organizations also may submit comments independently.

## **Consider Cultural Changes Necessary to Optimize Advanced Alternative Payment Models**

RWJF applauds CMS for all of the work they have done thus far to move Alternative Payment Models (APMs) forward. We recognize, however, APMs are not the end goal in themselves but a technical vehicle for improving population health at lower cost. We have seen in our work the importance not only of addressing technical fixes related to payment and delivery system reform, but also addressing cultural challenges that often stand in the way of change. Therefore, we encourage CMS to consider cultural changes are also needed to look toward next steps of integrating advanced APMs as part of SIM. For example, in our work, we are finding that lack of trust is a major concern. Even with some of our work which appears more technical, such as the measuring [Total Cost of Care](#) initiative, where regional health improvement collaboratives are bringing together multi-stakeholder groups to make data driven change to improve value, there is a recognition that a key part of these efforts relates to building trust and relationships within health care systems and across stakeholders so together they trust the data, trust in the use of the data, and trust that their best interests are accounted for.

Similarly, trust is also a major issue in understanding what matters to patients as they seek to make health care decisions in partnership with their providers. In a project we are calling [Right Place, Right Time](#), we engaged Oliver Wyman and Altarum Institute to conduct interviews, focus groups, and a survey to better understand consumer's information needs in the health care system and learned from this work that there is a real, pervasive lack of trust, especially among certain more historically disadvantaged populations. If changes in payment and delivery system continue, without addressing trust between patients and providers and between providers and other parts of the health care system, it will be difficult if not impossible to make real progress in improving health outcomes.

As part of building trust with and engaging patients and caregivers, we encourage CMS to focus on measures that orient the system toward putting patients and families at the center of care and treatment decisions. We are working now with American Institutes for Research and other partners to determine principles of true patient-centered measurement- measures that are useful to and resonate with people across settings, populations, and geographies. We will gladly share this information with CMS when it is completed as well as information on the other programs listed above.

## **Fostering Cross Sector Collaboration to Improve Well-Being**

We know that up to 40 percent of health outcomes are driven by nonmedical factors and CMS has demonstrated its recognition of the importance of multiple factors in shaping health as part of their growing body of population health work, including Accountable Communities for Health. As CMS considers next stages of SIM and incorporating advanced APMs, we encourage the agency to facilitate state capacity to help foster connections across health care, public health, and social services. As CMS thinks about next steps for the SIM Initiative, it will be helpful if APMs were designed from the outset to reflect the impact of social needs on health. This will help create incentives for states to establish on-the-ground partnerships between health care and other

sectors. One way to foster this collaboration is by choosing measures of success relevant to population health and also by ensuring that financial accountability and reward are shared across health care, public health, and community based organizations.

Another way to help foster this local level collaboration and alignment is by aligning SIM strategies with community level health improvement planning and leveraging community health improvement processes. We have seen that public health departments can be left behind in the health care delivery transformation, so it is especially important to encourage collaboration here because public health has data, analysis, convening, strategic planning and monitoring, and evaluation capacity to offer. RWJF is working with the [Public Health Accreditation Board](#) and other partners to weave together specific innovations to demonstrate the value of the well-designed and well-resourced public health system in building a Culture of Health at the community level. Innovations include public health agency accreditation; defining cross-cutting public health agency capabilities that form the necessary foundation for effective delivery of health services; and developing a national uniform chart of accounts that provides a standardized way to categorize and measure investments in public health.

In addition, we encourage CMS to expand and strengthen their work with other agencies as part of the next phase of SIM. For example, we know through our work on the [6/18 initiative](#) that the partnership between CMS and CDC is working well and is providing concrete help and technical assistance for states to change their Medicaid approaches to pay for population health. We are also seeing through this initiative the opportunity to strengthen the relationship between Medicaid and public health agencies in states, through clear and tangible work that can then contribute to meaningful ongoing collaboration.

### **Strengthening Integration of Services and Systems to Empower Patients and Providers**

Another critical piece of the next stages of state transformation is to ensure states balance the need to move health care transformation forward, while at the same time ensuring that the gap in health care delivery is not widened in under-resourced communities. For example, safety net providers will require support and resources to take on financial risk, including upfront payments to make necessary investments in infrastructure and the workforce. States will need to assist safety net providers in moving along a clearly defined and reasonable path that phases such providers into more advanced APMs, while not disrupting existing relationships with patients and community-based supports. Medicaid programs often lack the infrastructure to support sophisticated payment models given archaic information systems that do not support real time data sharing and performance monitoring. Programs like the CMS Comprehensive Primary Care Plus (CPC+) that encourage Medicaid providers to build upon familiar foundational patient centered medical home (PCMH) components while providing additional funding and resources to build out more sophisticated approaches provide a great model.

RWJF is supporting programs like [Health Leads](#) and [Medical-Legal Partnership](#), which work to integrate care to meet people's whole needs—behavioral and physical health, addressing social needs, and also addressing the trauma people have experienced in their lives that may be at the

root of what has brought them into the health care system. Fostering an integrated care approach will be critically important to the success of APMs moving forward. We are learning through work with these organizations that there is a return on investment when people are given access to services that meet their social needs in meaningful ways.<sup>1</sup> Especially through our [trauma-informed care work](#), we are seeing that much remains to be done in this regard—from making it easier to share data across systems, to identifying screening tools to assess patient histories relevant to traumatic experiences, to training staff at all levels to take a trauma-informed approach to identifying the right measures that can help with quality improvement and establishing incentives.

RWJF also is developing a program related to connecting systems of health care and social services under which we will support learning, relationship-building, collaboration, and action related to connecting health care and community-based social services in innovative ways and to building more integrated local and regional delivery and payment systems of health care and social services. We will soon release a request for information relevant to this program and can share the results with CMS once it is complete.

### **Resources and Tools States Need to Design and Launch Multi-Payer Delivery and Payment Reforms**

The Foundation has learned several important lessons through multiple state-focused projects about the critical ingredients for success. First, we learned that strong leadership is paramount. Specifically, the commitment of leadership to transformation has been shown to be critically important across the most successful initiatives happening in the country. This will be important not only in the governor's office but also for other agencies at the table—from Medicaid to public health and social services and other departments. Commitment to system change will need to withstand administration changes, political pressures, and competing state priorities, so it is important the belief in this work come not only from the person at the top but deeper in the state agencies as well. So, as CMS decides the best ways to target their grant and TA dollars, they should consider the level and depth of state interest in these efforts.

Second, it is important for CMS to help states foster multi-sectoral engagement, to help bring new partners to the table in addition to standard ones, including consumer groups, patient groups, social service organizations, etc. States will likely be more inclined to engage multi-stakeholders, if it is clear that federal partners are supportive and strengthening these partnerships as part of the overall transformation work.

Third, it is important for CMS to build trusted, productive relationships with states as they design the resources and tools to help them. One of the projects we supported, a NGA Policy Academy on Medicaid transformation, was very successful because NGA helped states navigate their important relationships with CMS, helping them to have productive conversations with, and access to, CMS officials. As part of this work, NGA released a [toolkit for states](#) that will be

<sup>1</sup> Evaluations are forthcoming and we can provide them to CMS if interested once released.

helpful to them as they navigate this work with CMS, but the toolkit may be helpful to CMS as well in recognizing where states are coming from.

Fourth, we learned how much states appreciate learning from one another through peer-to-peer opportunities. It will be important for CMS, working with partners, to foster opportunities for states to connect with one another to share learning about success and failure. RWJF has extensive experience across multiple programs in organizing learning collaboratives and convenings—virtually and in person—and would be happy to share this information with CMS as agency officials develop the next iteration of the SIM Initiative.

Fifth, we believe that one of the most important things that CMS can offer states is flexibility. Flexibility must be provided in funding so that states can provide the services people need to improve their health, even if these services are provided outside the traditional clinical setting. This also means flexibility in adapting federal requirements to specific state challenges, appreciating that states are in very different places and have different needs depending on capacity, resource issues, and political will. As it is important not to increase disparities in health through CMS transformation efforts, thinking about the best ways to address needs in each state will be important. We have seen from the first rounds of the SIM initiative that states that waited to engage in payment and delivery system reform efforts are at a distinct disadvantage in achieving sustainable reforms because of the lack of continued funding opportunities. Additionally, these lagging or “have not” states are often those that need the most help with planning and programmatic assistance due to a lack resources.

Lastly, flexibility must be offered as it relates to time. We recognize that CMS has budgetary pressures and constraints. However, states may need more time to show meaningful impact on outcomes related to well-being as they look outside the health care system to address a whole person’s needs. This is especially true when it comes to efforts to improve outcomes for kids.

## **Conclusion**

In conclusion, RWJF believes the SIM initiative is critical to building a Culture of Health in states and communities. We appreciate the opportunity to provide our views to CMS and are happy to answer any questions on these comments as well as provide additional information on any of the programs we mentioned. We look forward to future collaboration on this important initiative.

Sincerely,

A handwritten signature in black ink, appearing to read "Risa Lavizzo-Mourey".

Risa Lavizzo-Mourey  
President and CEO



1

October 27, 2016

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AllMeds, Inc.  
Allscripts Healthcare Solutions  
Amazing Charts  
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Cerner Corporation  
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STI Computer Services  
Viant Medical Solutions, Inc.  
Varian Medical Systems  
Wellsoft Corporation

Representing more than 30 companies that develop and support electronic health records (EHRs) in hospitals and ambulatory care environments across the US, the Electronic Health Record Association (EHRA) offers the following input to the Request for Information (RFI) on State Innovation Model Concepts. We commend the Centers for Medicare and Medicaid Services (CMS) and the states to pursue the objectives outlined in the RFI.

As reflected through a number of questions in the RFI and the overall objectives set out through the State Innovation Model (SIM) initiative, the opportunity to accelerate healthcare transformation in and across states has a critical dependency on the ability of information to flow among clinicians, payers, and state agencies. Interoperability will be a key component of the efforts to achieve the stated goals, such as what we have seen with the federal goals around Medicare.

We have recognized that, through the roll-out of the EHR Incentive Program and certified electronic health record technology (CEHRT) to our clients across all states, variations in implementation approaches unnecessarily complicate these projects and add effort for everybody without noticeable benefits. Considering those experiences, we would like to share the following considerations as CMS and the states further their efforts through SIM in the context of Section I, Question 3, "Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data."

We encourage all states, when considering how they might enhance interoperability, to evaluate opportunities both to reduce the barriers to exchange and to recognize

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and support alternative means to exchange and interoperability outside of a health information exchange (HIE), including applying and more fully utilizing the standards that certified EHR vendors already must support. For example, adopt common quality measure definitions and interoperability standards (including reporting standards), such that data can be exchanged consistently within and across states using a common superset of definitions with state-specific subsets rather than variant approaches common to date.

State level programs that build on the nationally required set of interoperability standards can gain more rapid adoption and expansion, as far less incremental work would be necessary to implement and deploy the desired interoperability.

We will continue to participate in the dialog on this important topic, both at the state and national levels, and look forward to working with all stakeholders to educate provider executives, physicians, and legislators as we collaborate to achieve this important goal. The EHR Association recognizes that increasing interoperability both locally and across communities is essential in achieving our shared objectives of a more efficient, effective healthcare system for all Americans.

Sincerely,



Sasha TerMaat  
Chair, EHR Association

Epic



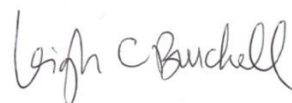
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#### About the EHR Association

Established in 2004, the Electronic Health Record (EHR) Association is comprised of over 30 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.

The EHR Association is a partner of HIMSS. For more information, visit [www.ehrassociation.org](http://www.ehrassociation.org).





**STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES**

**Earl Ray Tomblin  
Governor**

**Office of the Secretary**  
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**Karen L. Bowling  
Cabinet Secretary**

**RE: Request for Information (RFI) on State Innovation Model Concepts**

Dear Center for Medicare & Medicaid Innovation:

This letter is a response to the request for information released by the Center for Medicare & Medicaid Innovation (CMMI) on September 6, 2016. We, the State of West Virginia and its partners in the State Innovation Model (SIM) process, welcome and thank you for the opportunity to share insights about the future of the SIM program and the health care needs of the state. West Virginia was selected by CMMI in February 2015 as a Round 2 SIM design state, and it was expected to deliver a final State Health System Innovation Plan (SHSIP) by January 31, 2016. CMMI granted the state a six-month no-cost extension, which moved the final submission deadline to July 31, 2016. West Virginia's SHSIP was submitted to CMMI on July 21, 2016. The SHSIP was accepted and approved by CMMI on October 3, 2016.

Although this letter offers extensive detail about West Virginia's health care environment and proposes numerous types of assistance and policy changes that might be pursued, we believe the greatest help that CMMI can provide is by continuing with a SIM Round 3—that is, offering implementation funding to Round 2 design states.

**Impact of the SIM Program**

A September 2016 brief published by the National Academy for State Health Policy detailed the general successes of the SIM program.<sup>1</sup> We concur with the brief's synopsis of the importance of the SIM program. We also view the stakeholder development aspects of the SIM program as an invaluable outcome just as important as the SHSIP. The SIM process provided a vehicle to convene stakeholders; assure accountability for timelines; benefit from peer learning and benchmarking with other states and technical assistance. This was invaluable to our efforts to develop an approach for health improvement in a manner that meets the needs of West Virginians.

<sup>1</sup> National Academy for State Health Policy. A federal-state discourse on maintaining momentum for payment and delivery system reform. <http://www.nashp.org/wp-content/uploads/2016/09/Discourse-Brief.pdf>. Published September 20, 2016. Accessed October 11, 2016.

## West Virginia's Growing Budget Challenges<sup>2</sup>

As other SIM states noted in the National Academy for State Health Policy brief, West Virginia is concerned about making continued progress toward delivery and payment transformation without ongoing funding to move from SIM planning to testing. This reality, among several contextual considerations, influenced the goals and design of West Virginia's approach to payment reform and health system transformation. First, state and local government agencies are under extraordinary financial pressures due to reliance on the energy industry as a major driver of employment and tax revenue. Energy industries such as coal mining and natural gas drilling have historically been major employers and contributors to the state and local governments through severance taxes. The energy sector in West Virginia has experienced a period of market fluctuation with suppressed demand and prices that may be symptomatic of long-term trends, particularly in certain segments of the coal industry. These market pressures have adversely impacted employment and tax revenues for the state, compounding the challenge of funding innovations in health care delivery and services.

Current budget shortfalls constrain the ability of public payers to sustain continued growth in health care expenditures for the Medicaid program, the state Public Employees Insurance Agency and public health services. Cost pressures also have affected the state's human assets and bandwidth in health services-related agencies—leaving state government, *on its own*, incapable of leading the change necessary to transform the state's health care system. Accordingly, the strategies outlined in our SHSIP rely heavily on a public-private partnership approach. A coalition of likeminded organizations and individuals are prepared to assist the state (and take a leadership role, if desired) in developing the technical expertise and bandwidth to pursue value-based health care transformation. To continue positive momentum from the SIM process, the SHSIP recommends the creation of a public-private partnership, the West Virginia Health Transformation Accelerator (WVHTA), to oversee the execution of the SIM plan and related endeavors. The WVHTA is currently being established as a legal entity, but the conceptual framework for the organization already exists and stakeholders are meeting/strategizing now. In this letter, the WVHTA is proposed as a key organization to act on behalf of West Virginia stakeholders to coordinate health improvement and transformation initiatives.

Ensuring that the state makes the most efficient use of its limited financial resources and moves forward with health care transformation, including the adoption and proliferation of alternative payment models (APMs), it is imperative that West Virginia implement its SHSIP proposals and recommendations. Likewise, it is vital that West Virginia continue to receive financial and technical assistance from CMMI and other federal agencies in these endeavors.

<sup>2</sup> Information in this section was derived from Section 5 of the SHSIP, which can be found as follows. West Virginia State Innovation Model Grant. West Virginia state health system innovation plan. <http://www.wvhicollaborative.wv.gov/Documents/West%20Virginia%20SHSIP%20with%20Cover%20Letter%20and%20Errata.pdf>. Published August 5, 2016. Accessed October 12, 2016.

## **West Virginia's Many Population Health Problems**

West Virginia is beset by numerous population health problems. The state leads the nation in the number of smokers as a percentage of the population; the number of poor physical health days taken in the last month; the amount of heart disease as a percentage of the adult population; the prevalence of high blood pressure in the adult population and the percent of adults with diabetes.<sup>3</sup> This state of unhealth creates a cycle that reinforces the population health status quo and further deteriorates the state economically. For instance, worker productivity is significantly lower in West Virginia than in other states, as evidenced by the number of poor health days taken in the last month and other metrics. Lower productivity due to health factors exacerbates the state's economic crisis as people drop out or are intermittently engaged in the workforce. West Virginia, in fact, has one of the worst workforce participation rates in the country, with less than 50% of its noninstitutionalized population age 16 or older working.<sup>4</sup>

The cost of this poor population health is borne predominantly by the state and federal governments and by state-based health care providers. Approximately three-quarters of West Virginia's population is covered by some form of government-supported health insurance, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or the state Public Employees Insurance Agency.<sup>5</sup> Medicare, in particular, plays a disproportionate role in West Virginia's delivery and payment system. In fact, about 23% of West Virginians are covered by Medicare, tying the state with Maine for the highest proportion of Medicare coverage nationally.<sup>6</sup> These unique West Virginia characteristics create opportunities for federal partnership and assistance. West Virginia's poor population health status means there are tremendous health care savings opportunities, as well as possibilities to rapidly improve the state's national ranking. Finally, the concentration of public payers within West Virginia makes organizing the health insurance market toward common goals easier than in other states.

### **How the Centers for Medicare & Medicaid Services (CMS) and CMMI Can Help West Virginia**

The aforementioned challenges focus our priorities on a narrow set of health care projects. Generally, West Virginia would benefit most from federal support that:

1. Offers maximum flexibility while operating within defined goals and objectives established by CMS/CMMI (e.g., like the SIM program);

<sup>3</sup> United Health Foundation. 2015 annual report: West Virginia. <http://www.americashealthrankings.org/explore/2015-annual-report/state/WV>. Published December 10, 2015. Accessed October 12, 2016.

<sup>4</sup> Figures from the U.S. Bureau of Labor Statistics peg West Virginia's labor participation rate at 49.4% in 2015. United States Department of Labor Bureau of Labor Statistics. States: Employment status of the civilian noninstitutional population, 1976 to 2015 annual averages. <http://www.bls.gov/lau/rdscnp16.htm>. Published September 20, 2016. Accessed October 18, 2016.

<sup>5</sup> State of West Virginia Offices of the Insurance Commissioner. Accident and health insurance market report 2016. <http://www.wvinsurance.gov/Portals/0/2016%20A%20%20H%20Report%20Final.pdf>. Published July 20, 2016. Accessed October 12, 2016.

<sup>6</sup> The Henry J. Kaiser Family Foundation. Medicare beneficiaries as a percent of total population. <http://kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/>. Published March 2016. Accessed October 12, 2016.

2. Permits testing of innovation with willing partners in the state and the scaling up of the most successful models; and
3. Includes technical assistance from CMMI, other relevant subject matter experts and fosters dialogue or facilitates a learning community of SIM states.

Support would be used for projects identified in our SHSIP; these projects (and related endeavors) are detailed in the following section.

### **SHSIP-Aligned Projects and Policies**

#### *Projects and Policies that Create a Culture of Health and Wellness*

##### Try This West Virginia

During the SIM planning process, public health stakeholders identified West Virginians' culture of poor health and sense of fatalism and hopelessness about improving socio-economic status and health outcomes as key roadblocks to the state achieving positive population health.<sup>7</sup> West Virginia believes it must combat that perception through hundreds of community-based partnerships, media and information campaigns that create a widespread understanding that West Virginia has a rapidly growing healthy community movement and that a healthy West Virginia is possible. Indeed, such a movement is already underway through community-based programs such as Try This West Virginia.

Try This West Virginia advances practice-based, affordable and practical community health improvement projects grounded in the socio-ecological model of health promotion supported by the Centers for Disease Control and Prevention (CDC). As a coalition of more than 20 statewide groups, Try This West Virginia provides mini grants to local grassroots teams to develop projects that expand healthy community choices and build *local leadership*. The program has demonstrated through 153 community projects since its inception in 2014 that people can make changes in their lifestyles more easily if healthy choices are available in their community.

Try This West Virginia projects have received incredible buy-in, as they have leveraged \$8 for every \$1 in grant funding provided for the 153 community projects. Community teams engage each other and network through a large annual conference, considerable social media presences and a well-resourced website, [www.trythiswv.com](http://www.trythiswv.com). In the SIM Round 2 Review Cover Letter received from CMMI on October 3, 2016, the CDC remarked that "attempting to address the basic needs of [health care super-utilizers] this vulnerable population by including community partners and providing opportunities for them to explore lifestyle change activities through the Try This West Virginia" is a strong approach.<sup>8</sup> Given the CDC's embrace of the Try

<sup>7</sup>The SIM Better Health Workgroup, using a Likert Scale from one (strongly disagree) to 10 (strongly agree), was surveyed using Qualtrics about attitudes toward public health based on comments made by participants in the initial Better Health Workgroup meeting. The culture of poor health statement received an 8.15 score, and the sense of fatalism and hopelessness statement received an 8.09 score. The response rate for the survey was 46%. Workgroup membership at the time (July 2015) was 74 individuals.

<sup>8</sup>Traylor J. R2D SHSIP review cover letter WV. Received via e-mail. Published October 3, 2016. Accessed October 14, 2016.

This West Virginia model, resources and funding to further scale up the approach in West Virginia and other states is warranted. Additionally, federal partners such as the Appalachian Regional Commission and other state partners, including Kentucky and North Carolina, have expressed interest in replicating the model. The CDC-funded West Virginia Prevention Research Center is currently working with Try This West Virginia to conduct an independent evaluation of the model. This creates an opportunity for collaboration among the states, CDC, the Appalachian Regional Commission and CMMI to explore a grassroots population health intervention model.

### Accountable Health Communities (AHC)

We strongly support holistic care models, such as AHC, that help curb unhealthy behaviors, promote healthy lifestyles, address chronic diseases and ultimately progress the state toward value-based health care.<sup>9</sup> West Virginia health care providers and social service organizations applied for a funding opportunity through CMMI for AHC. Track 2 of this funding opportunity, which is being pursued by a consortium including Charleston Area Medical Center, Partners In Health Network and the West Virginia University Center for Excellence in Disabilities, will provide community navigation services to assist high-risk Medicare and Medicaid beneficiaries with access to social services.

There is a major opportunity for alignment between AHC and Medicaid Affordable Care Act Section 2703 health homes—discussed in greater detail on page 8—that could occur if CMMI made coordination a higher priority and more explicit. States should be able to leverage the staffing resources of the Medicaid health homes for AHC or AHC-like activities and vice versa. Yet, there are three significant hurdles to accomplishing this goal.

1. The population served through Medicaid health homes is, of course, limited to the Medicaid population—unlike AHC which also includes Medicare beneficiaries.
2. The chronic conditions codified in the Affordable Care Act for the health home are narrow and specific and other conditions can only be approved after a lengthy review process.
3. The core staffing structure for the health home is fairly proscriptive—leaving little flexibility to add or change members of the *core care team*.

An additional item requires further clarification by CMMI. The AHC FAQ guidance states that “[AHC] cooperative agreement funds may not be used to provide individuals with services that are already funded through any other source, including but not limited to Medicare, Medicaid, and CHIP.”<sup>10</sup> Thus, it is uncertain if health home and AHC resources can be shared to address the needs of the same beneficiaries or those in similar populations. CMS/CMMI can help address

<sup>9</sup> Alley D, Asomugha, CN, Conway, PH and Sanghavi, DM. Accountable Health Communities – Addressing social needs through Medicare and Medicaid. *N Engl J Med*. 2016; 374(1): 8-11. doi: 10.1056/NEJMp1512532.

<sup>10</sup> Centers for Medicare & Medicaid Services. Accountable Health Communities model- Frequently asked questions. <https://innovation.cms.gov/initiatives/ahcm/faq.html>. Published October 12, 2016. Accessed October 17, 2016.

this issue by promulgating clear rules/cooperative agreements defining when and where health home and AHC resources can be used and/or shared.

Our SHSIP proposes using health homes as a potential way to implement the AHC concept in lieu of receiving a cooperative agreement with CMMI, but this approach is too narrow and shortsighted. We anticipate that the health home and AHC models will need to be complementary and mutually-reinforcing, as they will likely serve many of the same vulnerable populations if not the same Medicaid beneficiaries. Once an effective advanced primary care delivery system has been built to serve Medicaid beneficiaries (i.e., the health home), it should, concurrently, be able to serve other populations of Medicaid beneficiaries, as well as Medicare and CHIP beneficiaries and the commercially insured. Medicare could also support the participating health home primary care practices through an APM to promote sustainability and advance MACRA/MIPS priorities. Medicare's involvement is especially important and timely given the finalization of MACRA/MIPS rules regarding health homes *not qualifying* as an APM.<sup>11</sup> We encourage CMS/CMMI to investigate ways of incorporating Medicare beneficiaries into the health home concept, fostering Medicare/Medicaid collaboration as it has done for the AHC cooperative agreement.

### *Projects and Policies for Health Information Technology and Data*

#### The Need for Medicare and Non-Health Claims Data

West Virginia's Department of Health and Human Resources operates a Medicaid data warehouse that includes all traditional Medicaid, Medicaid managed care and CHIP claims. A logical next step is to utilize the data warehouse and its associated analytics capability for Medicare claims data. The West Virginia Bureau for Medical Services, the state Medicaid agency, has attempted numerous times to acquire Medicare claims data for non-dual eligibles, but it has so far been unsuccessful in securing data from CMS. West Virginia strongly urges CMS to develop a streamlined process for states to request and receive Medicare claims data. Failure to analyze these data creates a large blind spot in any value-based transformation efforts, particularly in our state where Medicare beneficiaries constitute nearly a quarter of the insured population.

CMS has taken a strong leadership and facilitation role in encouraging other federal agencies to provide non-health claims data in an efficient and usable way. We applaud these efforts and hope that these will be continued and expanded. Having access to non-health claims data, such as Supplemental Nutrition Assistance Program data from the U.S. Department of Agriculture, population health data from the CDC and non-CMS data within the U.S. Department of Health & Human Services, helps create a fuller patient profile to address the social determinants of health. We suggest that CMS consider the creation of a data clearinghouse that states could use to request and receive non-health claims data for Medicare and Medicaid beneficiaries.

<sup>11</sup> Dickson V. MACRA rule deals blow to docs in Medicaid medical homes.

<http://www.modernhealthcare.com/article/20161017/NEWS/161019916>. Published October 17, 2016. Accessed October 19, 2016.



## Streamlining and Achieving Common Quality Measures

Multipayer health care systems often send mixed guiding and incentivizing signals to providers. In the typical environment, including West Virginia, providers collect and report hundreds of different metrics to their payer partners. This creates significant financial, administrative and resource burdens for providers and hinders attempts to improve population health or the delivery system. The alignment of measurement and quality improvement goals will be key to transforming West Virginia's health care system. The SHSIP endorses CMS's Core Quality Measures Collaborative as a starting point for quality measurement alignment.<sup>12</sup> SIM Round 3 funding could support the convening of state stakeholders under the auspices of the WVHTA for the purpose of aligning quality measures that further SHSIP and state public health priorities.

### *Projects and Policies Related to APMs and Delivery Transformation*

#### Comprehensive Primary Care Plus (CPC+)

CPC+, another CMMI initiative, offered a significant step forward for primary care adoption of APMs. CPC+ was introduced during the final quarter of our SIM planning process, permitting the concept to be presented and to be explained to primary care practitioners and payers in West Virginia. CPC+ received an extremely positive reception; it was considered by many large primary care practices as a viable method of supporting and sustaining meaningful care coordination teams. Nonetheless, the initial plan for CPC+ required private insurance companies to buy-in and prepare APM models in a relatively brief period of time. We propose two key changes to CPC+ recruitment that would encourage wider participation, particularly from regions that most need the financial assistance and practice transformation CPC+ affords.

1. Because West Virginia is dominated by federal payers, as previously noted, implementing a project such as CPC+ in the state would require *full* federal payer participation and a longer timeline for the recruitment of payers and eventually providers due to state staffing deficits/bandwidth and the lack of value-based infrastructure.
2. Potential waivers of CPC+ programmatic requirements (on a case-by-case basis) for the less advanced value-based health care states would also be necessary.

If CPC+ were to accept West Virginia (or part of the state) as a region, it would promote exploration of APMs in different, typically smaller-sized primary care practices. Furthermore, this action would present an important opportunity for the federal government to see how CPC+ works in a rural state with comparatively poor APM adoption. Making programmatic changes that facilitate adoption of CPC+ in rural, medically underserved areas will allow West Virginia to keep pace with advanced value-based states that are better resourced and structured to transform their health care systems.

<sup>12</sup> Centers for Medicare & Medicaid Services. Core measures. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html>. Published February 16, 2016. Accessed October 14, 2016.

### Medicaid Health Homes

We encourage CMS to use existing authority to improve, expand and make more flexible the Affordable Care Act Section 2703 health homes. West Virginia recently concluded a health home for Medicaid beneficiaries with bipolar disorder and hepatitis B/C or who are at risk of contracting hepatitis B/C. Regrettably, the 90-10 match for the health home, per the law, was capped at eight quarters. For a long-term illness such as hepatitis B/C, this two-year timeline may not demonstrate cost savings or budget neutrality.<sup>13</sup> Since budget neutrality is required for any Medicaid managed care change and for the state to support a project, especially in this tough fiscal climate, it is unlikely this specific health home will be replicated by managed care organizations or continued by traditional Medicaid. We offer three recommendations to CMS for future approval of health homes.

1. We recommend that CMS allow states to seek a waiver to the eight quarters of 90-10 enhanced match—taking into account the difficulty and clinical nature of the diseases to be addressed and/or the lack of experience in advanced primary care delivery and intensive care coordination that some states face.
2. We recommend that CMS be more flexible in its interpretation of a health home in terms of conditions covered and staffing structure and be better aligned with CMMI projects, as noted on pages 5 and 6 related to AHC.
3. We recommend that CMS be quicker in approving health homes. Back dating the 90-10 match causes confusion for providers, patients and the West Virginia Bureau for Medical Services, the state Medicaid agency, as well as creates an artificial time clock under which services are to be provided to our most vulnerable citizens. CMS should exercise discretion about when to begin the enhanced match period for a health home in consultation with its state partner.

### Primary Care - Behavioral Health Considerations and Demonstrations

West Virginia recognizes that behavioral health-related issues are major drivers of healthy or unhealthy choices and have an impact on the burden of illness. Behavioral health conditions are also major contributors to avoidable utilization of health care services and other inefficiencies in the health care system. Moreover, West Virginia—like many rural states—suffers from an inadequate and asymmetric supply of behavioral health professionals. The SIM Project Management Team used a CMMI-approved resource, the Agency for Healthcare Research and Quality's The Academy for Integrating Behavioral Health and Primary Care, to develop a roadmap for integration. In fact, a leadership team member from The Academy was engaged by the SIM Project Management Team to assist in developing a West Virginia-specific integration plan.

<sup>13</sup> WVDHHR Bureau for Medical Services. West Virginia health homes inaugural year 2014-2015 annual report. <http://www.dhhr.wv.gov/bms/BMSPUB/Documents/HealthHomesAnnualReport%20Final%20Version.pdf>.



To address behavioral health challenges and strategize for effective behavioral health and primary care integration, the West Virginia SIM Project Management Team formed a specialized *ad hoc* workgroup. The workgroup adopted the following seven principles—devised with the assistance of a The Academy leadership team member—to combat West Virginia’s behavioral health problems and to achieve behavioral health and primary care integration. Note that bolded principles are discussed as areas for CMMI involvement/assistance.

1. Continue to promote collaboration between the primary care and behavioral health communities that fosters integration of behavioral health into primary care and ensures that persons cared for in behavioral health settings are getting optimal primary care support.
2. Broaden support for and remove barriers to using telehealth.
3. **Implement the Project for Extension for Community Healthcare Outcomes (ECHO) and similar models using telehealth to make specialist expertise more broadly available throughout West Virginia with an initial focus on opioid and other types of substance abuse.**
4. **Promote the collaborative care/consulting psychiatrist model to improve treatment of common, less serious behavioral health disorders in primary care.**
5. Broaden the use of community health workers, health educators, peer coaches for substance abuse disorders and peer services for mental health; standardize training and certification.
6. Revise academic curricula for health professions to support team-based models that integrate behavioral health and primary care.
7. **Continue to participate and encourage greater involvement in behavioral health demonstrations and pilots that put the state at the forefront of new types of delivery and payment models.**

Project ECHO is a telehealth application that expands access to specialty care and builds workforce capabilities to address complex chronic conditions. Originally, the project started in New Mexico for hepatitis C treatment, but it has since expanded to include other regions and chronic diseases. Project ECHO uses videoconferencing technology to create knowledge-sharing networks between specialists and primary care providers in rural or underserved communities. Under this model, specialists provide best-practice education to primary care teams, enabling them to provide specialty care services in their own communities. In spring 2016, West Virginia started a Project ECHO for hepatitis C and is developing an ECHO clinic to improve care for those suffering from chronic pain. The chronic pain ECHO is scheduled to launch in January 2017. We encourage CMS/CMMI to adopt and promote the Project ECHO model as a way to expand specialty care and consider funding demonstrations specifically to address systemic and nationwide behavioral health specialist shortages using ECHO.

Another telehealth model worth expanding and pursuing is the Collaborative Care Model as supported by The AIMS Center at the University of Washington. The Collaborative Care Model is based on five core principles: 1. patient-centered team care, 2. population-based care, 3. measurement-based treatment to target, 4. evidence-based care and 5. accountable care.<sup>14</sup> This model uses a core team of primary care providers, behavioral health providers or case managers and psychiatrist consultants working together to treat depression, anxiety and other chronic health and behavioral health conditions. A CMMI- or Patient-Centered Outcomes Research Institute-funded demonstration project for rural states, such as West Virginia, to deploy the Collaborative Care Model would be a welcome opportunity. West Virginia has made major strides to develop its telehealth infrastructure, yet it is comparatively behind in the delivery of behavioral health services via telehealth.

#### Health Care Payment Learning & Action Network (HCP-LAN) Bundled Payment Demonstrations

In recent months, former SIM Project Management Team members have facilitated exploratory maternal bundled/episodic payment discussions using the materials from HCP-LAN as guidance for the payer and provider stakeholders. Because of West Virginia's budget constraints described previously, when considering incorporating this sort of innovation into Medicaid managed care contracts, our state requires a proven return on investment in terms of quality and cost. SIM Round 3 funding would allow for a systematic study of bundled payments and their effect on health outcomes and cost, as well as provide enhanced access to technical resources and consulting expertise.

### **Conclusion**

To reiterate the theme of this letter and our SHSIP, the absence of SIM Round 3 funding (or some similar vehicle for testing and implementation), will make it difficult for our rural state with an older and sicker population to effectuate the intended system transformation objectives of MACRA/MIPS. This will create additional financial strain on Medicare and Medicaid programs in West Virginia for CMS. But, if SIM Round 3 funding were made available, West Virginia will test the innovations in our SHSIP in alignment with the objectives of CMS for accelerating the movement of hospitals, physicians and other providers to APMs consistent with MACRA/MIPS. Moreover, funding will allow our state to bolster allied initiatives, such as our State Health Plan, which is presently being developed using the SHSIP as a foundational document, to better target and plan West Virginia's health care future.

In West Virginia, Medicare has the most to gain from the savings generated from many of the health innovations in our SHSIP. SIM Round 3 funding would provide support for practice transformation and facilitate efforts with Medicaid managed care organizations and commercial payers to incentivize providers in reducing avoidable hospitalizations, readmissions and emergency department use through expanded patient-centered medical homes and health homes; more effective care transitions; population health management and the use of health information technology and data to risk stratify and prioritize interventions based on health and social determinants data.

<sup>14</sup> Information concerning the Collaborative Care Model is available at <http://aims.uw.edu/collaborative-care>.

Please feel free to contact the former SIM Project Manager Thomas E. Gilpin at (304) 293-6615 or at [tegilpin@hsc.wvu.edu](mailto:tegilpin@hsc.wvu.edu) should you have questions or require further information concerning this letter. Thank you again for the opportunity to provide our insights, comments and opinion about the future of the SIM program.

*This letter is respectfully submitted by the following parties on behalf of their respective organizations.*

West Virginia Department of Health and Human Resources

*cJ'yu4*

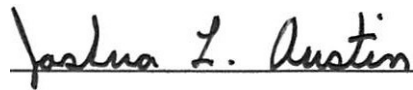
Karen L. Bowling, Cabinet Secretary

AND



West Virginia SIM Project Management Team

Thomas E. Gilpin, Former SIM Project Manager



Joshua L. Austin, Former SIM Project Coordinator



Division of  
**Health Care  
Finance & Administration**

October 28, 2016

Dr. Patrick Conway  
Deputy Administrator for Innovation and Quality  
Centers for Medicare and Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244

Dear Dr. Conway,

Tennessee appreciates the opportunity to respond to CMS' Request for Information on State Innovation Model concepts related to state-based payment and delivery system reform initiatives.

Tennessee has been at the cutting edge of innovations in health care for over 20 years. As the first state in the nation to move to 100% Medicaid managed care, we've prided ourselves in continually raising the bar for health care payment and delivery system transformation. With the support of a \$65 million State Innovation Model: Model Test award, Tennessee is implementing an episodes of care model that has already demonstrated success in reducing health care costs and improving quality in our state.

**CMMI should give priority consideration to existing, successful, statewide, multi-payer programs such as episodes of care when evaluating Advanced Other Payer Alternative Payment model status under the Quality Payment Program.** Given Tennessee's demonstrated results, we believe CMS should recognize Tennessee's episodes of care model as an Advanced Other Payer Alternative Payment Model and allow providers who participate in episodes of care to qualify for the Alternative Payment Model incentive.

In addition, Tennessee welcomes Medicare fee-for-service's participation in our episodes of care model. Episodes of care meet all of the principles outlined by CMS in the April 10, 2015 guidance for Medicare alignment including being person-centered, accountable for total cost of care, transformative, broad-based, feasible to implement, and feasible to evaluate.

The Tennessee Health Care Innovation Initiative began designing episodes of care in 2013 as a way to move from paying for volume to paying for value. We believe the episodes of care model is one of the most broad-based, feasible to implement, and transformative ways to move the needle on health care spending. To date, Tennessee has designed and implemented 70 episodes

of care . The state is on track to have 75 episodes designed by 2020.

An evaluation of our first three episodes of care in the first year showed a reduction in costs of 3.4 percent in perinatal, 8.8 percent in asthma exacerbation, and 6.7 percent in total joint replacement (hips and knees). Overall, the cost for services in these three types of episodes was \$6.3 million less than the previous year, even though medical costs were projected to increase by 5.5 percent nationally (National Projection of the HHS office of the actuary.) Conservatively assuming a 3 percent increase would have taken place in the absence of this initiative, these episodes reduced costs by \$11.1 million. At the same time, quality of care was maintained according to the measures we track and tie to rewards payment. In future years we hope to see improvements in quality for these measures. We plan to continue evaluating each episode of care annually and will report our results as we finalize them to all of our stakeholders.

**Tennessee is also interested in participating in a multi-state evaluation of our episodes of care program.** Currently Arkansas, Ohio, and Tennessee have very similar episodes of care designs and could all be evaluated by CMS as part of a single evaluation. A robust evaluation of an episode would take at minimum one and a half years from the time an episode launched, but across our three states there are shared episodes of care already launched, which could be evaluated in a shorter timeframe.

Sincerely,



Brooks Daverman

Director of Strategic Planning and Innovation

Tennessee Department of Health Care Finance and Administration

Center for Medicare and Medicaid Innovation  
Request for Information on State Innovation Model Concepts  
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS  
ACTION: Request for Information (RFI)

## SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is seeking input on the following concepts related to state-based payment and delivery system reform initiatives:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could Qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying PM participants (QPs) and earn the APM incentive;<sup>1</sup>
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

DATES: Comment date: To be assured consideration, comments must be received by October 28, 2016.

ADDRESSES: Comments should be submitted electronically to: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov).

FOR FURTHER INFORMATION, CONTACT: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov) with "RFI" in the subject line.

## BACKGROUND

Section 1115A of the Social Security Act, as enacted by section 3021 of the Affordable Care Act, authorizes the Center for Medicare and Medicaid Innovation (hereafter, the Innovation Center) to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

CMS is issuing this Request for Information (RFI) to obtain input on potential state-based initiatives. While we seek public input on the areas described below, no decision has been made to offer awards in these areas.

Currently, CMS partners with states on state-based payment and delivery reform through the State Innovation Model (SIM) initiative. SIM was launched in 2013 to test the ability of state governments to use their policy and regulatory levers to accelerate healthcare transformation efforts in their states, with a primary goal to transform over 80% of payments to providers into innovative payment and service delivery models. CMS has set ambitious goals for health system transformation, and we recognize that much of this transformation will ultimately occur at the state and community level. Our investment in SIM is a recognition of the important role states play as a locus for change to accelerate transformation, and their unique leverage point to implement models consistent with the proposed Quality Payment Program<sup>2</sup> under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation. Through two rounds of SIM funding, CMS has supported collaboration between states and the federal government. SIM stakeholders have reported that CMS' funding and facilitation of multiple payers and providers were vital for the success of their process. These efforts have necessarily been multi-year processes, given the scope of system transformation tackled by states and their partners, and the need to build data infrastructure and partnerships across an entire state. The long ramp-up time needed for state-wide health care system transformation, including building the necessary infrastructure, can also require a subsequently long period to

<sup>2</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-PMs/Quality-Payment-Program.html>

Examine the impact of the initiative. This, coupled with delays in accessing data for the Medicaid population – the primarily impacted population – has created delays in timely impact results for the SIM initiative, and it is too early to attribute any quantitative results directly to SIM. However, early findings from the federal evaluation on the Round 1 states show promising results with states achieving transformation of their payment and delivery systems. Three Round 1 test states (Minnesota, Oregon, Vermont) are reaching over 50% of the state's population with SIM supported models, and two of those states (Oregon, Vermont) are reaching 80% of their Medicaid population, with significant payer and provider engagement. In addition, analyses on the Medicare and commercial populations show that SIM states were making progress on health outcomes, such as declines in hospital readmissions and reductions in emergency room visits, through initiatives pre-dating SIM and upon which SIM efforts are building. Future analyses will determine whether SIM accelerated these trends, particularly for the Medicaid population.<sup>3</sup>

CMS has continued to evolve our efforts during and across the two rounds of SIM funding to better support our state partners. We have emphasized sustainability and specific alternative payment models led by the state. We have encouraged states to participate in the Health Care Payment Learning and Action Network (LAN) as a tool to gain meaningful multi-payer participation, a key to long-term sustainability. And, recognizing the important role of Medicare in all-payer alignment at the state level, we have released guidance<sup>4</sup> in support of Medicare participation in state-based multi-payer models. Medicare alignment can play a critical role in the success of multi-payer models at the state level, whether through participating in a unique arrangement with a state, or by the state designing its multi-payer models to align with existing Medicare models. The multi-payer models enabled by Medicare participation hasten momentum among states to use their levers to accelerate payment and delivery transformation on a broad scale, and thereby enable states to use their unique capacity to affect improvements in the health of the entire state population.

CMS is interested in gathering information regarding potential state-based payment and delivery system reform initiatives in the following areas:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive;
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

We seek public comment on ways to support broad payer and health care provider participation in alternative payment models that could be Advanced Alternative Payment Models under the Quality Payment Program. Movement toward Advanced Alternative Payment Models under the Quality Payment Program will be challenging for many health care providers. We believe that states can play a key role to support eligible clinicians in moving into Advanced Alternative Payment Models, and help them to leverage financial incentives available through the proposed Quality Payment Program. For example, states can support the development of service delivery and payment models that align with Advanced APM or Advanced Other Payer APM criteria under the proposed Quality Payment Program rules, increasing opportunities for eligible clinicians to become QPs and earn the APM incentive, especially when all-payer concepts are introduced for the APM incentive in a few years.

<sup>3</sup> The evaluation reports can be found at <https://downloads.cms.gov/files/cmmti/sim-round1-secondannualrpt.pdf>.

<sup>4</sup> For more information see, <https://innovation.cms.gov/Files/x/sim-guidancemultipayeralignment.pdf> and <https://innovation.cms.gov/Files/x/sim-guidance-statesponsored.pdf>.



CMS seeks broad input from beneficiaries, consumers, and consumer organizations; providers, Indian health care providers; purchasers and health plans; social service agencies and providers; home and community-based services providers; Health IT and Health Information Exchange (HIE) vendors and associations; Governors; state offices including Medicaid, departments of health, public health, and social services; and other private and public stakeholders. Commenters are encouraged to provide the name of their organization and a contact person, mailing address, email address, and phone number. However, this information is not required as a condition of CMS' full consideration of the comments.

## SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

The Secretary has set a clear goal for moving the nation toward broad-scale adoption of alternative payment models: 50 percent of fee-for-service Medicare payments tied to alternative payment models that reward the quality of care by the end of 2018. Under the proposed Quality Payment Program, significant incentives will be in place to promote adoption of Advanced APMs under Medicare. The MACRA legislation phases in incentives for certain clinicians participating in models that also include Medicaid and private payers, with incentives available beginning in 2021 based on performance in a prior period—currently proposed to be 2019. CMS is also working with private payers through the LAN to accelerate adoption of alternative payment models, recognizing that multi-payer participation—including but not limited to Medicare—is essential to meeting the Secretary's goals.

Consistent with these efforts, CMS invites comments on concepts for a potential future state-based initiative that would support states to implement broad scale, multi-payer delivery and payment reforms that support health care providers entering into models that could qualify as Advanced Alternative Payment Models. These potential future initiatives would support states that have a clear end-vision of multi-payer alternative payment models inclusive of Medicare, and have a focus on the health outcomes of the entire population of a state through alignment of care delivery and payment.

CMS recognizes that there are multiple pathways to achieving this vision, and is interested in public input on ways to support states in developing the operational and infrastructure capacity needed to implement a multi-payer model that includes Medicare and could be an Advanced Alternative Payment Model, regardless of which pathway they pursue. We are seeking comment on two pathways, consistent with our two prior guidance documents on multi-payer models inclusive of Medicare:

### **1. A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation**

This pathway could be tailored for a state to launch a multi-payer model, inclusive of Medicare, Medicaid, and private payers, which could be an Advanced Alternative Payment Model. In order for Medicare to participate in a state-led model, a state would submit a proposal to CMS demonstrating how its proposed model meets the set of principles described in the April 10, 2015 guidance for Medicare alignment, and demonstrates that Medicare participation in a state-designed model will be a test of a new or novel model or a test adapted for the unique needs of a state that could be applied on a statewide basis. In order for Medicare to participate in a state-based all payer model, the model would need to be: 1) person-centered, 2) accountable for total cost of care, 3) transformative, 4) broad-based, 5) feasible to implement, and 6) feasible to evaluate.

<sup>5</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>.

## 2. Support states to align with existing Medicare models

The second pathway could be for a state to align Medicaid and private payers around one or more existing CMS models and initiatives (e.g., Medicare Shared Savings Program, Next Generation ACO Model, Comprehensive Primary Care plus (CPC+), Medicaid health homes, Medicaid integrated care models, or episode based payment models), such that a significant number of eligible clinicians in the state or region could become QPs and earn the APM incentive. This pathway is consistent with our guidance in November 2015 that provided further details on ways that states could align with existing CMS programs in order to achieve multi-payer participation inclusive of Medicare.

### QUESTIONS

What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?

a. What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?

*Nevada is unique in that it does not set its Medicaid rates according to DRG. The upgrade to the Nevada MMIS system will not occur until 2019.*

b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?

*Providers must be included, and their concerns must be addressed, in the process of creating any initiatives to ensure participation.*

c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program<sup>5</sup>?

*Although the Nevada Legislature enacted statutory language defining the PCMH model and allowing incentives between insurers and PCMHs, payment methodology must still be structured.*

d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?

*The Nevada SHSIP identified several areas for establishing reliable and consistent access to primary and behavioral health care services. Increased access to care will improve health outcomes statewide and particularly in the rural and frontier areas of the state that are underserved. These initiatives include the expansion of Community Health Workers (CHW), Community Paramedicine and Telehealth. (SHSIPpp. 68-70) Transforming provider practice*

*Requires changes in infrastructure and payment policies to encourage the use of innovative models to serve the health care needs of the citizens of Nevada. Funding for implementing or upgrading Electronic Health Records capabilities would encourage providers who are either reluctant or unable to invest in these systems. Changes in CMS policy to allow for Medicare payments for CHWs, Community Paramedicine and Telehealth services will not only enable providers to offer these services in their practice, but would be an incentive for private payers to do the same.*

*The State Innovation Model program garnered broad support due to the promise of financial and technological support associated with it. Payers, Providers and other stakeholders were able to think creatively and cooperatively because the financial burden associated with broad change was understood to be shared. Continued financial support for demonstration projects, technology infrastructure and other grants will be necessary to secure ongoing cooperation from this diverse group.*

e. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?

*Developing a plan and building operational capacity would require approximately 3-5 years for full implementation. Although the Nevada SHSIP Driver Diagram outlines steps to implement several of the identified initiatives, the process of obtaining provider and private payer participation in a test project will take time; the project should have at least a one-year testing and data gathering phase during which monitoring and adjustments can be made in preparation for expansion in either second or third year. Quality payment models must be proven financially effective for providers before they can be expected to wholeheartedly embrace them; communication among the State, Private Payers and Providers must be extensive and frequent.*

f. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?

*Although the models will be different, the goals will be the same or similar. Standards based on the shared goals will allow both CMS and the States to evaluate the varying levels of success of individual models with a degree of certainty.*

g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?

*Geography. Nevada faces challenges unique to the distribution of our population: 73% of the population is in urban Clark County, 17% in urban Washoe County/Carson City, and the remaining 10% located in frontier and rural Nevada. The Provider enticement to practice in rural/frontier areas is unique and an all-payer model may not be appropriate for this segment of Nevada. Nevada will be presenting innovative models to CMS to encourage teaching hospitals to partner with healthcare providers in rural locations.*

2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.

a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.

*In rural areas, the stigma associated with behavioral health services remains a challenge for service delivery. Co-location of primary health care and behavioral health care by encouraging CCBHCs and PCMHs to coordinate services is a strategy to be explored.*

*Due to Nevada's rural/frontier areas, we face challenges with the support staff needed to gather the data and complete the reporting necessary to measure these services. Nevada rural providers also face connectivity challenges for services as basic as telehealth. Nevada is participating with four rural hospitals in the FCHIP.*

b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?

c. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?

*The biggest challenges are the shortage of specialists and subsequent access to care*

3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.

a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?

*We do not have an APCD in Nevada, in fact we are still in the process of on-boarding payers and providers onto our Nevada HIE. Unfortunately this is not a fully developed resource. Any trending that is measured and reported requires sourcing from various sites to obtain needed data and then manual manipulation. Nevada Medicaid does not integrate Medicare data.*

b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?

*Nevada Medicaid does not currently integrate Medicare-specific data to calculate quality and population health measures. This is a manual process when integrating Medicare-specific data to perform any comparisons/calculations listed above.*

c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?

d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?

*Nevada, with the assistance of HITECH funding, is working towards implementing the capacity, expertise and staff to accomplish the above benchmark calculations.*

e. What support can CMS provide to improve states' access to reliable and timely data?

*Nevada faces a workforce shortage and is currently trying to address the underlying causes and delays. Funding to assist Nevada Providers to participate in ongoing HIE participation in addition to CMS' support of on-boarding new providers and the ongoing performance of providers. Data entry incentive payments could be a way to offset the costs to Providers as well. Rural and frontier providers continue to face challenges with transmission of data due to lack of connection.*

f. How can CMS support improve access to and linkage with health outcomes measures data?

*Since Nevada is in the early stages of HIE implementation and participation it is still difficult to address the long-term benefits of access linked to health outcomes.*

g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?

*Currently, many compliance checks are performed as in-person visits to support the compliance and program and integrity checks.*

h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?

*Currently, Nevada is continuing its work on developing linking among the various data sources using a Master Patient Index.*

## SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

One key feature of the State Innovation Models Initiative is the flexibility afforded to states to design contextually-specific delivery and payment reforms. This flexibility is necessary given each state's unique market, population, and regulatory environment, and has resulted in a unique set of experiments in each state. For example, nearly every SIM state has implemented a care intervention to improve behavioral health services, but there is great variation across states in their approach: in terms of the types of payment mechanisms used, target populations and provider types, and the overarching models of behavioral health integration (e.g., coordinated care, co-located care, integrated care). While that was by design in SIM Round 1 and 2—these tests were looking at states' ability to use policy and regulatory levers to accelerate healthcare transformation efforts, not at the care

Interventions implemented as part of that transformation—CMS is also interested in seeking public input on evaluating specific care interventions.

CMS is interested in assessing the impact of specific care interventions across states. States would have the option of seeking these supplemental awards, and in return would agree to implement a standardized care intervention in areas CMS and states agree are high priority for rigorous assessment (e.g., care interventions for pediatric populations, physical and behavioral health integration, substance abuse/opioid use treatment, coordinating care for high-risk, high-need beneficiaries) and participate in a robust evaluation design led by CMS. Unlike SIM Round 1 and 2, states would forego the flexibility of varying the intervention, so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.

## QUESTIONS

1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).

2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?

*Nevada would like the opportunity to participate in future intervention and evaluation efforts. Depending upon the type of project and the need for contractual adjustments, 2-3 years could be necessary to fully implement any project. The need to partner with academic institutions and/or research experts could only be determined within the context of a specific project.*

3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.

4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.

*One of the greatest barriers in Nevada is the lack of options in rural and frontier counties. Creating partnerships with medical education providers as an incentive to establish clinics in these counties – particularly combined behavioral and primary health clinics – is one possible intervention. Collecting the basic health information electronically from these sites would advance the state's understanding of existing and emergent needs in these counties.*

## SECTION III: STREAMLINED FEDERAL/STATE INTERACTION

States are critical partners in achieving the Secretary's goals for broad-scale adoption of alternative payment models. Accordingly, the Department of Health and Human Services (HHS) has invested in a number of initiatives across a broad range of agencies to provide funding, technical assistance, guidance, and regulations to enable, support, and accelerate state reforms—including the Innovation Center, the Office of the National Coordinator, Marketplaces, Medicare, Center for Medicaid and CHIP Services, Medicaid State Operations and Technical Assistance, the Medicaid Innovation Accelerator Program, and the Health Care Payment Learning and Action

Network. While these efforts have contributed to successes—CMS estimates that it achieved its goal of tying 30 percent of Medicare payments to alternative payment models ahead of schedule—it can be difficult for states to participate in these efforts. CMS seeks input on how to improve both coordination among related federal efforts in support of state-based delivery and payment reform efforts (e.g., workgroups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

## QUESTIONS

1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?

*Nevada has engaged with several federal efforts, including the SIM project, CCBHC, FCHIP and IAP. A single point of contact with streamlined web portal linking the various projects would be a useful addition to communication between state and federal agencies involved in these efforts. Even with increased inter-agency communication at the State level, linkages can be missed resulting in duplication of efforts and reduced productivity.*

2. How can CMS/HHS better align in order to support state delivery system reform efforts?

*Clearly stating the alignment of CMS/HHS goals as part of delivery system reform efforts assures better understanding by the states of the directions to be taken. In addition, it is useful when proposed projects are structured with a suggested topic for reform, a primary goal – reduced cost, expanded services, or improved outcomes – and a suggested outline. The states can then tailor their responses and reform efforts to work within their individualized reimbursement programs.*

**SPECIAL NOTE TO RESPONDENTS:** Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

**THIS IS A REQUEST FOR INFORMATION (RFI) ONLY.** This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment

Would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.



**Center for Medicare and Medicaid Innovation**  
**Request for Information on State Innovation Model Concepts**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS

**ACTION:** Requestor Information (RFI)

**SUMMARY**

The Centers for Medicare & Medicaid Services (CMS) is seeking input on the following concepts related to state-based payment and delivery system reform initiatives:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive;<sup>1</sup>
2. Implementing financial accountability for health outcomes for an entire state's population;
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4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

**DATES:** *Comment date:* To be assured consideration, comments must be received by October 28, 2016.

**ADDRESSES:** Comments should be submitted electronically to: SIM.RFI@cms.hhs.gov.

**FOR FURTHER INFORMATION, CONTACT:** SIM.RFI@cms.hhs.gov with "RFI" in the subject line.

**BACKGROUND**

Section 1115A of the Social Security Act, as enacted by section 3021 of the Affordable Care Act, authorizes the Center for Medicare and Medicaid Innovation (hereafter, the Innovation Center) to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

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<sup>1</sup> Please see proposed rule here: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-All-Payer-Overview.pdf>.

Models. CMS has set ambitious goals for health system transformation, and we recognize that much of this transformation will ultimately occur at the state and community level. Our investment in SIM is a recognition of the important role states play as a locus for change to accelerate transformation, and their unique leverage point to implement models consistent with the proposed Quality Payment Program<sup>2</sup> under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation.

Through two rounds of SIM funding, CMS has supported collaboration between states and the federal government. SIM stakeholders have reported that CMS' funding and facilitation of multiple payers and providers were vital for the success of their process. These efforts have necessarily been multi-year processes, given the scope of system transformation tackled by states and their partners, and the need to build data infrastructure and partnerships across an entire state.

The long ramp-up time needed for state-wide health care system transformation, including building the necessary infrastructure, can also require a subsequently long period to examine the impact of the initiative. This, coupled with delays in accessing data for the Medicaid population – the primarily impacted population – has created delays in timely impact results for the SIM initiative, and it is too early to attribute any quantitative results directly to SIM. However, early findings from the federal evaluation on the Round 1 states show promising results with states achieving transformation of their payment and delivery systems. Three Round 1 test states (Minnesota, Oregon, Vermont) are reaching over 50% of the state's population with SIM supported models, and two of those states (Oregon, Vermont) are reaching 80% of their Medicaid population, with significant payer and provider engagement. In addition, analyses on the Medicare and commercial populations show that SIM states were making progress on health outcomes, such as declines in hospital readmissions and reductions in emergency room visits, through initiatives pre-dating SIM and upon which SIM efforts are building. Future analyses will determine whether SIM accelerated these trends, particularly for the Medicaid population.<sup>3</sup>

CMS has continued to evolve our efforts during and across the two rounds of SIM funding to better support our state partners. We have emphasized sustainability and specific alternative payment models led by the state. We have encouraged states to participate in the Health Care Payment Learning and Action Network (LAN) as a tool to gain meaningful multi-payer participation, a key to long-term sustainability. And, recognizing the important role of Medicare in all-payer alignment at the state level, we have released guidance<sup>4</sup> in support of Medicare participation in state-based multi-payer models.

Medicare alignment can play a critical role in the success of multi-payer models at the state level, whether through participating in a unique arrangement with a state, or by the state designing its multi-payer models to align with existing Medicare models. The multi-payer models enabled by Medicare

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<sup>3</sup> The evaluation reports can be found at <https://downloads.cms.gov/files/cmml/sim-round1-secondannualrpt.pdf>.

<sup>4</sup> For more information see, <https://innovation.cms.gov/Files/x/sim-guidancemultipayeralignment.pdf> and <https://innovation.cms.gov/Files/x/sim-guidance-statesponsored.pdf>.

participation hasten momentum among states to use their leverage to accelerate payment and delivery transformation on a broad scale, and thereby enable states to use their unique capacity to affect improvements in the health of the *entire* state population.

CMS is interested in gathering information regarding potential state-based payment and delivery system reform initiatives in the following areas:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive;
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

We seek public comment on ways to support broad payer and health care provider participation in alternative payment models that could be Advanced Alternative Payment Models under the Quality Payment Program. Movement toward Advanced Alternative Payment Models under the Quality Payment Program will be challenging for many health care providers. We believe that states can play a key role to support eligible clinicians in moving into Advanced Alternative Payment Models, and help them to leverage financial incentives available through the proposed Quality Payment Program. For example, states can support the development of service delivery and payment models that align with Advanced APM or Advanced Other Payer APM criteria under the proposed Quality Payment Program rules, increasing opportunities for eligible clinicians to become QPs and earn the APM incentive, especially when all-payer concepts are introduced for the APM incentive in a few years.

CMS seeks broad input from beneficiaries, consumers, and consumer organizations; providers, Indian health care providers; purchasers and health plans; social service agencies and providers; home and community-based services providers; Health IT and Health Information Exchange (HIE) vendors and associations; Governors; state offices including Medicaid, departments of health, public health, and social services; and other private and public stakeholders. Commenters are encouraged to provide the name of their organization and a contact person, mailing address, email address, and phone number. However, this information is not required as a condition of CMS' full consideration of the comments.

## **SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

The Secretary has set a clear goal for moving the nation toward broad-scale adoption of alternative payment models: 50 percent of fee-for-service Medicare payments tied to alternative payment models that reward the quality of care by the end of 2018. Under the proposed Quality Payment Program, significant incentives will be in place to promote adoption of Advanced APMs under Medicare. The MACRA legislation phases in incentives for certain clinicians participating in models that also include Medicaid and private payers, with incentives available beginning in 2021 based on performance in a prior period—currently proposed to be 2019. CMS is also working with private payers through the LAN to accelerate adoption of alternative payment models, recognizing that multi-payer participation—including but not limited to Medicare—is essential to meeting the Secretary's goals.

Consistent with these efforts, CMS invites comments on concepts for a potential future state-based initiative that would support states to implement broad scale, multi-payer delivery and payment reforms that support health care providers entering into models that could qualify as Advanced Alternative Payment Models. These potential future initiatives would support states that have a clear end-vision of multi-payer alternative payment models inclusive of Medicare, and have a focus on the health outcomes of the entire population of a state through alignment of care delivery and payment.

CMS recognizes that there are multiple pathways to achieving this vision, and is interested in public input on ways to support states in developing the operational and infrastructure capacity needed to implement a multi-payer model that includes Medicare and could be an Advanced Alternative Payment Model, regardless of which pathway they pursue.

We are seeking comment on two pathways, consistent with our two prior guidance documents on multi-payer models inclusive of Medicare:

### **1. A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation**

This pathway could be tailored for a state to launch a multi-payer model, inclusive of Medicare, Medicaid, and private payers, which could be an Advanced Alternative Payment Model. In order for Medicare to participate in a state-led model, a state would submit a proposal to CMS demonstrating how its proposed model meets the set of principles described in the April 10, 2015 guidance for Medicare alignment, and demonstrates that Medicare participation in a State-designed model will be a test of a new or novel model or a test adapted for the unique needs of a state that could be applied on a statewide basis. In order for Medicare to participate in a state-based all payer model, the model would need to be: 1) person-centered, 2) accountable for total cost of care, 3) transformative, 4) broad-based, 5) feasible to implement, and 6) feasible to evaluate.

## 2. Support states to align with existing Medicare models

The second pathway could be for a state to align Medicaid and private payers around one or more existing CMS models and initiatives (e.g., Medicare Shared Savings Program, Next Generation ACO Model, Comprehensive Primary Care plus (CPC+), Medicaid health homes, Medicaid integrated care models, or Episode-based payment models), such that a significant number of eligible clinicians in the state or region could become QPs and earn the APM incentive. This pathway is consistent with our guidance in November 2015 that provided further details on ways that states could align with existing CMS programs in order to achieve multi-payer participation inclusive of Medicare.

### QUESTIONS

What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?

Prior to receiving the SIM Grant, Arkansas began health care transformation endeavors which dovetailed seamlessly with CMS's SIM efforts under the Affordable Care Act (ACA). This commitment remains even after Arkansas officially completed the three-year Round 1 SIM Grant model testing period. Thus, the state maintains a high level of interest in sustaining and expanding its realization of multipayer value-based delivery models. The work undertaken has been documented in SIM Grant reports submitted to CMS, and have been evidenced as well by participation in CPC, CPC+ and conversations with CMS regarding a state-wide integrated PCMH/Medicare Model. Information about some Arkansas Health Care Payment Improvement Initiative (AHCPII) achievements can be found on the AHCPII website: <http://www.paymentinitiative.org/> and in the Second Annual Statewide Tracking Report from ACHI (Arkansas Center for Health Improvement): <http://www.achi.net/Docs/338/>.

- a. What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?

Arkansas has achieved multipayer participation led by Arkansas Medicaid and including the state's largest private carriers and self-insured employer purchasers. Medicare participation in the state has been limited to the Comprehensive Primary Care Program (CPC) for which 69 original practices were selected. It is anticipated that Medicare participation in the state will be substantially increased beginning in 2017 through the Comprehensive Primary Care Plus (CPC+) Program for which Arkansas was selected.

Arkansas is interested in exploring further Medicare alignment in the state's existing programs including PCMH, Episodes of Care, and further integration of traditional Medicaid.

Arkansas is also seeking Medicare alignment with goals to align service delivery for individuals who need long-term services and supports, those with developmental disabilities, and behavioral health services for the severe and persistently mentally ill. Medicare alignment with reforms in these areas, including for the development of an Arkansas health homes model, would reinforce the state's current activities and integration of these services within PCMH practices.

In mid-2017, Arkansas Medicaid will have a new MMIS system in operation that will greatly enhance its capacity to analyze and rapidly report program performance from its already-sophisticated claims warehouse. The payer community continues to work together on managing common performance metrics and report cards. It is actively exploring information technology solutions with ONC to reduce the administrative and financial burdens to the provider community in reporting timely clinical data from electronic medical records.

- b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?

Factors essential for successful multipayer delivery system reform include multipayer alignment of strategy to the extent possible including:

- Support for provider transformation in the form of extensive outreach is critical; without this essential foundation for providers from our vendors, we believe that our providers would not have been as successful as they have been;
- Use of a single input portal and/or data extraction from EHR software to track metrics;
- Use of a unified HIE system;
- Aligned quality measure selection and expectations for provider financial targets;
- Use of a common provider reporting platform;
- Aligned programmatic timelines and administrative activities;
- Various and ongoing stakeholder engagement inclusive of patients, providers and associations and local policymakers;
- Sufficiently advanced data analytic capacity to produce provider reports and evaluate program outcomes;
- In order to reinforce delivery system reform, exploration of and use of policy levers across initiatives such as state Medicaid coverage expansion efforts and HIE and EHR linkages;
- Regular multipayer collaboration including strategy meetings and operational meetings

Future state-based initiatives can support these factors by including them in model design and operational strategy, both from a technical support standpoint and as consideration for necessary Medicare financial support proportionate to the number of Medicare beneficiaries impacted.

- c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program<sup>5</sup>?

Arkansas has developed a PCMH model that is a multipayer, team-based primary care strategy that has experienced marked success and garnered broad provider and legislative support. This model has been developed and implemented, and now has matured with several years of extensive provider and stakeholder engagement. Arkansas recently was selected for CPC+ and the state's multipayer group is working to align with the yet-to-be-finalized CPC+ criteria and measures. For any providers or practices not in CPC+, Arkansas seeks future Medicare support in the state's PCMH program. This way, non CPC+ practices who serve Medicare beneficiaries will be provided with PMPM support and incentives that are appropriate and proportionate to their attributed Medicare beneficiaries.

Opportunities for communications with CMS and CMMI are needed to align Arkansas efforts with the finalized Quality Payment Program criteria for Advanced APMs. MACRA language defines an eligible APM as an entity that either bears more than nominal financial risk for monetary losses under the APM; or is a medical home expanded under CMS Innovation Center authority via an 1115A(c) waiver. We presume that a successful State Innovation Model (SIM)/CMMI-funded model, such as Arkansas's PCMH program, would be considered an eligible APM. Medicaid's currently-implemented medical home model should meet criteria comparable to medical homes expanded under section 1115A(c) of the Act.

As a SIM Round-1 Test State, development of Arkansas's current PCMH program was supported by funding from CMMI, with Federal oversight regarding model design parameters and program evaluation. Arkansas was also selected to participate in the Comprehensive Primary Care (CPC) Initiative, which was authorized under authority of CMMI under a section 1115A waiver. Arkansas's

<sup>5</sup> <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>.

Current PCMH model is similar in many ways to the CPC model, and the state's model is arguably more robust than the CPC model in terms of quality measures and provider requirements. Arkansas's current PCMH model is authorized under the State Plan Amendment (SPA) approval process under authority of the Centers for Medicare and Medicaid Services (CMS) Under Section 1932 of the Social Security Act.

d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?

Arkansas will need CMS technical assistance and flexibility with actuarial estimates for Medicare and multipayer cost targets, as well as assistance with developing programmatic formulas for total cost of care that will serve to set provider expectations for accountability without holding providers accountable for care that is reasonably not within their realm of influence.

The overall rationale for cost exclusion and inclusion is that the program seeks to hold primary care providers accountable for total costs associated with treatments and services that they can control. Currently, Arkansas's PCMH model cost methodology reflects the high proportion of pediatric beneficiaries covered under the model. The current methodology excludes some services including neonatal ICU costs prior to an initial primary care provider (PCP) office visit. Costs are also excluded related to services for those individuals needing severe mental health treatments. These costs are excluded because they do not represent a typical course of treatment for the majority of the population for which a PCP is directly responsible.

It is anticipated that for an adult population, programmatic exclusions will include costs associated with nursing homes and long-term services and supports, while prescription drug costs may be considered for inclusion. While providers have little control over drug pricing, historical drug price variation can be captured in benchmark calculations against which providers are measured, and inclusion of drug costs in total cost of care calculations may incentivize providers to regularly assess patients' different kinds of prescriptions, and to prescribe generic drugs when appropriate.



More broadly, there is the potential for exogenous factors to impact the state's Medicare and multipayer cost growth in unpredictable ways. For example, Arkansas could adopt new system-wide technology at a different time than other states, or experience inflation of costs in specific localized areas such as treatment of Hepatitis C. The state could experience a localized disease outbreak that does not occur in other parts of the nation. Additionally, projections are based on the recent expansion of care in the state under the Affordable Care Act. Any significant change to the number of covered lives in the state due to legislative action could impact future targets. Under the model, Arkansas may submit to CMS feedback on any exogenous factors' impact on the model, including a suggestion to adjust the model on the basis of those exogenous factors. Any such adjustment would be at the sole discretion of CMS.

- e. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?

Based on Arkansas's experience as a SIM Grant Round 1 Test State, the three (3) year model testing period should be extended to a minimum of five (5) years and a maximum of seven (7) years if CMS were to continue its program in at least one more "Round". Although Arkansas was able to accomplish significant forward movement during the three years it was given, it is important to keep in mind that 1) health care reform was already underway in the state, and 2) it also encountered unexpected impediments that might have been overcome if given an additional two-year period with continued support from CMS.

Arkansas could reasonably expand current efforts and implement new, ongoing activities within 18 to 24 months given the state's progress in delivery system reform efforts. Arkansas would be able more accurately set near-term, intermediate, long-term and global goals across a five-year period than a shorter timeframe. Also, the longer five-year period would allow Arkansas to undertake sufficient risk mitigation strategies when (not if) unforeseen circumstances arise.

Considering the experience and lessons learned from Arkansas and other national payment reform leaders, any states that have not begun delivery reform efforts would likely need a minimum of 24 months to three years to begin to develop and implement multipayer reforms.

- f. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?

CMS should consider the need to work closely with states to tailor evaluation strategies

Based on state-specific reform components. The experience of SIM states working with CMMI to develop state-specific self-evaluation plans should be replicated in future efforts. It is likely that most states have a unique and vital understanding of the feasibility of conducting evaluations based on their local payer interactions, provider landscape, and knowledge of state and regional variation and historical operational nuances.

For the purpose of CMS conducting independent evaluations, CMS should consider choosing evaluators that already have historical and baseline knowledge of previous state efforts and knowledge of key payer- and provider-stakeholders.

- g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?

In considering overlap of current state models and potential new CMS Medicare-specific models, CMS should consider the program design of existing state models so that providers are further supported in current efforts with minimal additional administrative or reporting requirements. CMS should also consider the volume of Medicare beneficiary needs and service utilization as a proportion of states' overall utilization and cost of care, and provide proportionally appropriate financial support to participating providers. CMS should try to align with existing state based models to the extent possible.

2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.

- a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.

Arkansas has included several measures in its PCMH and Episodes of Care program models that are aimed at or can impact population health outcomes. As provider EHR functionality continues to improve, additional measures will be added to the state's programs to capture population health outcomes. Examples of the state's existing measures that would align with Medicare populations include but are not limited to:

- Percentage of CHF (congestive heart failure) beneficiaries on beta blockers;

- Upper Respiratory Infection: Appropriate antibiotic treatment for adults;
- Regular monitoring of the beneficiaries prescribed Coumadin and have a INR (international normalized ratio) test completed every 12 weeks;
- Percentage of diabetic beneficiaries who complete annual HbA1C, between 18-75 years of age;
- Percentage of diabetic beneficiaries between 18-75 years of age who are on statin medication;
- Percentage of beneficiaries greater than 18 that receive alprazolam;
- Percentage of beneficiaries 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

- b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?

In 2013, the Arkansas Department of Health estimated that almost 45% of Arkansans live in rural areas.<sup>6</sup> According to the most recent data, there are 55 rural counties<sup>7</sup> (out of 75 total) in Arkansas under the Office of Management and Budget's definition<sup>8</sup>. Further, 42 counties are considered to be in the Delta Region as defined by the Delta Regional Authority.<sup>9</sup> A full 20% of the population in the Arkansas Delta Region lives in poverty<sup>10</sup>.

*According to the Picture of Rural Health in Arkansas: A Call to Action:*

At the nexus of these shortcomings [lack of jobs and education and the second highest poverty rate in the nation] lies a unifying rural quality that serves as the incubator for health disparities and poor health outcomes in rural Arkansas: Poor access to health care.<sup>[11]</sup>

<sup>6</sup> Arkansas Department of Health, 2013. *Arkansas's Big Health Problems and How We Plan to Solve Them*, 11. Retrieved from

<http://www.healthy.arkansas.gov/aboutADH/Documents/Accred/ARHealthReportHealthProblems.pdf>. See also the Health Active Arkansas Plan. Retrieved from

[https://healthyactive.adh.arkansas.gov/assets/docs/\\_HAAplan\\_FINAL\\_WebView.pdf](https://healthyactive.adh.arkansas.gov/assets/docs/_HAAplan_FINAL_WebView.pdf)

<sup>7</sup> United States Census Bureau, February 2013. State-based Metropolitan and Micropolitan Statistical Area Maps. Retrieved from [http://www2.census.gov/geo/maps/metroarea/stcbsa\\_pg/Feb2013/cbsa2013\\_AR.pdf](http://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Feb2013/cbsa2013_AR.pdf)

<sup>8</sup> See Federal Office of Rural Health Policy, *Defining Rural Population*. Retrieved from <http://www.hrsa.gov/ruralhealth/aboutus/definition.html>

<sup>9</sup> [http://dra.gov/images/uploads/content\\_files/DRA\\_AR\\_2015.pdf](http://dra.gov/images/uploads/content_files/DRA_AR_2015.pdf)

<sup>10</sup> Delta Regional Authority, 2015. *Today's Delta: A Research Tool for the Region*, 2nd Ed. Feb. 2015, 2, 22-23. The total population of the Delta Region in Arkansas is 1,431,110, and the total number of people living in poverty is 286,222 (20%). Retrieved from [http://dra.gov/images/uploads/content\\_files/Todays\\_Delta\\_FINAL\\_print-w-borders.pdf](http://dra.gov/images/uploads/content_files/Todays_Delta_FINAL_print-w-borders.pdf)

<sup>11</sup> University of Arkansas for Medical Sciences, 2012. *The Picture of Rural Health in Arkansas: A Call to Action*, 3. Retrieved from <http://regionalprograms.uams.edu/wp-content/uploads/2016/02/ruralHealthPicture.pdf>

Access to care is one of the most prevalent and persistent issues facing this state. Over six (6) percent of households have no vehicle, and three (3) percent have no telephones.<sup>12</sup> If one or both parents are fortunate enough to have a job, the “lack of time off work” may prevent attention to health needs<sup>13</sup> for both parents and children. Thirty-seven (37) percent of Arkansas jobs are low-wage jobs, and 80% percent of low-wage earners do not earn any paid sick time.<sup>14</sup> Further, Arkansas has no paid family leave requirements,<sup>15</sup> leaving families a difficult choice between earning a paycheck, or caring for a sick child or newborn baby (or themselves).

Two age-based populations are especially vulnerable in this environment: the young and the old.

The Annie E. Casey Foundation’s 2015 Kids Count Data Book ranks Arkansas 44th in the nation in overall child well-being, lower than in previous years.<sup>16</sup> Specifically in the Delta Region, the poverty rate for those under 18 years of age rises to 29.4%,<sup>17</sup> and 26% state-wide.<sup>18</sup>

Arkansas Children’s Hospital, which treats Arkansans across the state, cited additional health and societal factors when considering “what is a healthy child”. These influences included: health coverage, screenings and access points under access to care; mental health and substance use; homelessness; parental support; oral health, living wages/job opportunities.<sup>19</sup>

Similarly, Arkansas’s aging population also faces troubling challenges. *See generally* Arkansas Department of Human Services, Division of Aging and Adult Services, *Arkansas State Plan on Aging, Fiscal Years 2016-2019*.<sup>20</sup> Elderly Arkansans reported the fourth (4th) lowest level of

<sup>12</sup> U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, cited by Arkansas Children’s Hospital, Spring 2016. *Community Health Needs Assessment: Exploring the Health Needs of Arkansas’s Youngest Residents*, 38. Retrieved from <http://www.archildrens.org/media/file/ACH-CHNA-2016.pdf>

Community health needs assessments may also serve as a guide for appropriate measures of success for social and public health services. Measures may include hospital reported rates of obesity, substance abuse and mental health issues, health education, diabetes, and other identified needs such as food insecurity and teen pregnancy. CHNAs offer an opportunity to catalyze health improvement within communities and ensure that hospitals, community organizations, and government entities have the information necessary to address community needs. Identification of common needs and shared resources among communities in Arkansas with an eye toward statewide initiatives bolsters the state’s chances to advance the health of Arkansans. A Fact Sheet prepared by ACHI contains more information about CHNAs, and can be found at <http://www.achi.net/Docs/342>

<sup>13</sup> ACH CHNA, 38.

<sup>14</sup> ACH CHNA, 35, 38.

<sup>15</sup> ACH CHNA, 38.

<sup>16</sup> ACH CHNA, 32. *See* <http://www.aecf.org/>

<sup>17</sup> DRA, *Today’s Delta: A Research Tool for the Region*, 23.

<sup>18</sup> ACH CHNA, 34.

<sup>19</sup> ACH CHNA, 18-21.

<sup>20</sup> [http://www.daas.ar.gov/pdf/State%20Plan\\_Final.pdf](http://www.daas.ar.gov/pdf/State%20Plan_Final.pdf)

health status in the nation.<sup>21</sup> Specifically, older citizens are facing: premature death; food insecurities but also an 11% increase in obesity; lower education; and low incidence of diabetes management among other factors.<sup>22</sup>

Further, few of the aging in Arkansas are able-bodied. They face the fifth highest level in the nation of preventable hospitalization; increased levels of hospital readmissions; the highest level of falls accompanied by the fourth (4th) highest level of hip fractures.<sup>23</sup>

These age-based populations intersect when examining behavioral health and developmental disabilities. According to Arkansas Children's Hospital:

One in five Arkansas children under age 5 has at least one emotional or behavioral difficulty, and 16 percent of children screened in pre-k programs have significant behavioral concerns. These concerns continue to develop in adolescence and often occur along with other risky behaviors. Only 32 percent of youth age 12-17 received treatment for a major depressive episode.

Suicide is the second leading cause of death for children ages 1-18, and Arkansas's suicide rate for all ages is 48 percent higher than the U.S. rate. An increasing percentage of Arkansas youth (19 percent, up significantly from 14 percent in 2011) report having considered suicide in the past year. Alarming, 16.5 percent of youth have made a plan for suicide, and 10.8 percent have attempted suicide at least once time. Female (23.3 percent) and Hispanic (24.3 percent) youth consider suicide at much higher rates than average rates.<sup>[24]</sup>

Meanwhile, the elderly population struggles with cognitive difficulties, depression and frequent mental distress.<sup>25</sup>

This data underscores the need for both a pediatric and aging focus within the realm of payment improvement, creates significant opportunity to incorporate telehealth as a supporting structure for all aspects of health care delivery, and justifies the inclusion of social determinants within the scope of a holistic health care policy.

While there is not a physician shortage overall, providers are more densely located in urban

<sup>21</sup> UnitedHealth Foundation, 2016. *America's Health Rankings, Senior Report*, 66, 84. Retrieved from <http://cdnfiles.americashealthrankings.org/SiteFiles/PressReleases/Final%20Report-Seniors-2016-Edition.pdf> <sup>22</sup> UHF AHR, 56-78.

<sup>23</sup> Id.

<sup>24</sup> ACH CHNA, 40. Omitted citations: Arkansas's Strategic Plan for Early Childhood Mental Health. 2014 – 2015; Behavioral Health Barometer: Arkansas, 2013. SAMHSA last retrieved from <http://www.samhsa.gov/data/sites/default/files/Arkansas-BHBarometer.pdf> April 2016; Centers for Disease Control and Prevention, WISQARS database. Retrieved January 2016; Youth Risk Behavior Survey, 2013. <http://www.arkansascsch.org/tinymce/filemanager/files/2013ARH%20Detail%20Tables.pdf>

<sup>25</sup> UHF AHR, 56-78.

areas. Besides telehealth, two examples of population health informing health are local health units and community health workers. These two solutions only scratch the surface of actions and activities that can be undertaken to chip away at the enormous issues facing Arkansans today.

Arkansas has local health units in all counties that can offer a range of preventive services. These services can serve to reinforce PCMH goals in rural areas. To the extent that conditions with a high prevalence in Arkansas such as hypertension and diabetes can be categorized as public health issues, interventions such as Arkansas's PCMH program that include clinical measures of population rates of these conditions can be deemed appropriate measures of success.

Community health workers is another option that Arkansas has not had the opportunity to explore within its Payment Improvement activities. However, a study conducted in this state<sup>26</sup> showed a 23.8 percent average reduction in annual Medicaid spending per participant during the period 2005–08, and a net three-year savings to the Arkansas Medicaid program equal to \$2.619 million.<sup>27</sup>

- c. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?

Both of the issues raised (overlapping catchment areas and offering population-level services across state lines) are very real concerns in Arkansas. Services are concentrated and overlap in just a few metropolitan areas; at the same time, a large number of Arkansas Medicaid patients receive treatment across state lines in Texas, Louisiana, Mississippi, Tennessee, Missouri and Oklahoma.

Some of this disparity can be explained by the rural nature of the state. Other enabling factors need to be further researched, and addressed Utilizing the existing PCMH28

<sup>26</sup> *Community Engagement in Health-Related Research: A Case Study of a Community-Linked Research Infrastructure, Jefferson County, Arkansas, 2011–2013*. Retrieved from [http://www.cdc.gov/pcd/issues/2015/14\\_0564.htm](http://www.cdc.gov/pcd/issues/2015/14_0564.htm)

<sup>27</sup> Health Affairs, July 2011 vol. 30 no. 7 1366–1374. *Medicaid Savings Resulted When Community Health Workers Matched Those With Needs To Home And Community Care*. Retrieved from <http://content.healthaffairs.org/content/30/7/1366.full?ijkey=zrqbtjW.Gr7NQ&keytype=ref&siteid=healthaff>

<sup>28</sup> Arkansas's multipayer group has acted to attribute patients to primary care providers, and to make providers aware of their list of attributed patients, included their high-priority beneficiaries. Arkansas PCMH incentivizes both urban and rural providers to manage their entire patient population, and also incentivizes primary care clinics to work more closely with hospitals, specialists, and other providers to manage the patient care.

While Arkansas has expanded coverage under the ACA, most all of our neighboring states have not. While Arkansas hospitals have been supported by expansion, hospitals in neighboring non-expansion states have struggled. Several hospitals have closed near Arkansas in surrounding states such as Texas, Mississippi, Missouri, and Tennessee. While Arkansas hospitals are well positioned to continue to provide services and integrate system

model as the baseline for further development will provide a solid footing to include these items in a viable solution.

3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.

- a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?

The state is currently implementing its all-payer claims database (APCD) pursuant to Arkansas Act 1233 of 2015<sup>29</sup>, which may be used to calculate multipayer quality and cost/utilization metrics for higher-level program evaluation (e.g., historical trends and predictive analytics). Private insurers with medical, dental and pharmaceutical claims and covering at least 2,000 covered individuals are required to submit data to the APCD. As of September 2016, the APCD contains 2013 Medicare with 2014-2015 data anticipated to be received in spring 2017. The APCD also contains Medicaid and commercial carrier data spanning 2013-2015.

ACHI acts as the APCD administrator, and the Arkansas Insurance Department, in collaboration with a 13-member Transparency Initiative Board, authorizes use and disclosure of the data consistent with legislative intent.

At the individual payer level, payers maintain their own data and are currently tracking programmatic indicators for quality and cost and utilization. Payer databases and mechanisms to evaluate clinical data at the beneficiary level will be increasingly relied upon to provide performance data as requested by the provider community who will demand timely assessments of their progress on the metrics for which they are held accountable.

In general, to better serve Medicaid beneficiaries, it would be beneficial for Medicaid to have real-time access to Medicare data. Currently, Arkansas does not have that capability.

- b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a

transformation efforts with PCMH clinics and other providers, the impact of hospital closings in other states is a fundamental detriment to these kinds of activities and those state's ability to provide adequate population-level services.

<sup>29</sup> This law is known as the Arkansas Healthcare Transparency Initiative.

Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and healthcare data; appropriate measures)?

As detailed in the PCMH provider manual, the state PCMH program includes a range of quality and utilization measures, many of which are listed in the initial proposal document. In 2016 the state PCMH program will require all participating practices to be able to extract clinical and Meaningful Use (MU) data from their EHRs. In 2017 this MU data will actually be used to measure related health outcomes within the PCMH program.

The Arkansas APCD can calculate quality measures based on claims data and population health measures on a Medicare-specific and multi-payer basis. ACHI has previously performed the former function.

- c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?

T-MSIS has been in production since November 2015. Therefore, Arkansas Medicaid has the capacity to share data with CMS, and will be able to utilize T-MSIS to support efforts in 2017 and beyond.

- d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?

At an individual payer level, Arkansas has demonstrated the capacity, expertise and resources to perform benchmark spending calculations for Medicaid and participating private payers. This has been demonstrated through the state's payment improvement efforts inclusive of the state's patient-centered medical home (PCMH) program and Episodes of Care model.

To the extent that Medicare has participated in the Comprehensive Primary Care initiative in Arkansas, Medicare-specific analyses and calculations have been performed by CMS or CMS vendors. Should Medicare participate in state-based models in the future, it will be necessary for Medicare to provide resources to assist with Medicare-specific evaluations or multi-payer integration. This could be achieved through direct funding or staff allocations from CMS, or as a separate component of a single funding stream to the state in the form of Medicare beneficiary per-member per-month support. Given current technical capacity, outcome measures and payment tied to those measures continue to be a considerable technical hurdle.



- e. What support can CMS provide to improve states' access to reliable and timely data? Other states, such as New York, are working to integrate Medicare data into the Medicaid APMs and then integrate the Medicaid data into the various Medicare models if a provider is participating. Arkansas would like to be able to likewise integrate Medicare and Medicaid data with technical assistance from CMS, especially related to utilization of the Virtual Research Data Center or VRDC. CMS has also improved data provision to the state's providers through the state's participation in the Medicare Shared Savings Program ACO.

CMS should continue to provide data to the Arkansas APCD and the Arkansas Health Data Initiative, and to work with the state to provide a timely data submission and receipt process that is closer to real-time information.

- f. How can CMS support improved access to and linkage with health outcomes measures data? Arkansas continues to work with the Office of the National Coordinator for Health Information Technology (ONC) to refine specific applications for extraction of meaningful use-related clinical chart data from participating providers' EMR systems. This is part of an ongoing effort to move the state's PCMH model beyond primarily using claims data for reporting purposes. CMS should continue to offer direct staff support and technical assistance from ONC. CMS should also continue to assess state-specific provider EHR functionality and readiness to report electronic clinical quality measures (ECQMs) such as those proposed for CPC+.
- g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes? Arkansas Medicaid and the state's private payers have access to their own data and can perform program integrity checks and validate outcomes. Additionally, the State's all-payer claims database includes Medicare, Medicaid and commercial payer data.
- h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality? The state's progress in the PCMH and episodic models would not be possible without the investments that have been made in analytic and reporting infrastructure. Arkansas Medicaid has worked with Hewlett Packard Enterprises (HPE) and General Dynamics Health Solutions (GDHS) to develop an analytic engine and dashboard which enables the necessary reporting processes for both models. This IT functionality has to date processed billions of claims to generate thousands of provider reports. The Arkansas APCD also offers a multi-payer platform for data aggregation and analysis of claims data.

In another example of the state's multipayer collaboration, Arkansas Blue Cross Blue Shield (ARBCBS) has enabled the use of the Advanced Health Information Network (AHIN) as a common provider portal allowing access to provider reports across payers. Approximately 98% of providers in the state are registered AHIN users. A large and increasing number of providers have accessed their reports and made use of information that was previously not been available to them. The state is working with the Office of the National Coordinator for Health Information Technology (ONC) to refine specific applications for extraction of meaningful use-related clinical chart data from participating providers' EMR systems. Enhanced EMR extraction is part of a larger ongoing effort to move the state's PCMH model beyond relying primarily upon claims data for reporting purposes.

## SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

One key feature of the State Innovation Models Initiative is the flexibility afforded to states to design contextually-specific delivery and payment reforms. This flexibility is necessary given each state's unique market, population, and regulatory environment, and has resulted in a unique set of experiments in each state. For example, nearly every SIM state has implemented a care intervention to improve behavioral health services, but there is great variation across states in their approach: in terms of the types of payment mechanisms used, target populations and provider types, and the overarching models of behavioral health integration (e.g., coordinated care, co-located care, integrated care). While that was by design in SIM Round 1 and 2—these tests were looking at states' ability to use policy and regulatory levers to accelerate healthcare transformation efforts, not at the care interventions implemented as part of that transformation—CMS is also interested in seeking public input on evaluating specific care interventions.

CMS is interested in assessing the impact of specific care interventions across states. States would have the option of seeking these supplemental awards, and in return would agree to implement a standardized care intervention in areas CMS and states agree are high priority for rigorous assessment (e.g., care interventions for pediatric populations, physical and behavioral health integration, substance abuse/opioid use treatment, coordinating care for high-risk, high-need beneficiaries) and participate in a robust evaluation design led by CMS. Unlike SIM Round 1 and 2, states would forego the flexibility of varying the intervention, so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.

### QUESTIONS

1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically, we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).

Arkansas seeks to expand its current programs to include Medicare beneficiaries including PCMH, Episodes of Care, and ongoing support for CPC+. The state's efforts to date have already positioned Arkansas as a platform for evaluation of these interventions and programs (including CPC classic). Evaluators both in state and independently contracted with CMS have tracked and

evaluated Arkansas's experience which has been well documented in numerous publications. Given the maturity of Arkansas's interventions and the opportunity to expand these to include Medicare beneficiaries, the state aims to continue to work with CMS to serve as a platform to evaluate expanded interventions which may inform states pursuing similar strategies.

2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?

Arkansas is willing to standardize care interventions to an extent that is reasonable with consideration of the state's current programs and achievements, with deliberation around Arkansas provider and stakeholder relationships. While, to the extent possible, Arkansas anticipates aligning with current activities such as CPC+ and additional multipayer opportunities, any intervention that would randomly exclude Arkansas providers would be discouraged. Arkansas's goals for system transformation include participation of as many providers as possible. We feel that randomization in the form of provider exclusion from participation is not necessary for the purposes of assessing impact of interventions in Arkansas, and that other non-exclusionary research designs, such as practice-level year on year pre/post analyses, can have served to adequately evaluate the impact of interventions in Arkansas.

Arkansas Medicaid has an interagency agreement with the University of Arkansas for Medical Sciences, and in this agreement and other arrangements has worked to evaluate state interventions. It is anticipated that these relationships and resources will continue for these purposes.

3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.

Arkansas is seeking to test components of a health home model that would integrate with the state's PCMH program and include services for special needs populations, including those with behavioral health needs and those with developmental disabilities or needing long term services and supports.

4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.

Arkansas has worked to maintain coverage for vulnerable populations through traditional Medicaid and through the state's original version of Medicaid expansion within the state's Health

Care Independence Program. The expansion program has developed a new framework to maintain coverage expansion through a program called Arkansas Works. In both of these frameworks, commercial carriers offering qualified health plans (QPH) on Arkansas's exchange are able to offer coverage to eligible individuals. Also in both programs, the QHPs are required to support the state's PCMH program both financially and with access to population-level data for care management. Other states may use similar policy levers to reinforce payer support and provider participation in population based models aimed at improving care for all individuals.

Regarding the state's broader population health goals, Arkansas previously developed a SIM Population Health Plan and submitted it to CMS.<sup>30</sup> Some of those activities have been rolled into the recently-enacted Healthy Active Arkansas initiative. The HAA Plan can be accessed at [https://healthyactive.adh.arkansas.gov/assets/docs/\\_HAAplan\\_FINAL\\_WebView.pdf](https://healthyactive.adh.arkansas.gov/assets/docs/_HAAplan_FINAL_WebView.pdf).

### SECTION III: STREAMLINED FEDERAL/STATE INTERACTION

States are critical partners in achieving the Secretary's goals for broad-scale adoption of alternative payment models. Accordingly, the Department of Health and Human Services (HHS) has invested in a number of initiatives across a broad range of agencies to provide funding, technical assistance, guidance, and regulations to enable, support, and accelerate state reforms—including the Innovation Center, the Office of the National Coordinator, Marketplaces, Medicare, Center for Medicaid and CHIP Services, Medicaid State Operations and Technical Assistance, the Medicaid Innovation Accelerator Program, and the Health Care Payment Learning and Action Network. While these efforts have contributed to successes—CMS estimates that it achieved its goal of tying 30 percent of Medicare payments to alternative payment models ahead of schedule—it can be difficult for states to participate in these efforts.

CMS seeks input on how to improve both coordination among related federal efforts in support of state-based delivery and payment reform efforts (e.g., workgroups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

### QUESTIONS

1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?

Arkansas has remained ahead of most states in progress towards payment and delivery system reform, although the state has engaged with multiple federal efforts. The state has engaged

<sup>30</sup> The enumerated focus areas were tobacco prevention, diabetes, obesity, hypertension, substance abuse, breastfeeding/perinatal and health literacy.

Regularly with ONC and these efforts should continue to ensure Arkansas providers are supported in EHR use and that related expectations are forward leaning but not unreasonable, to foster interoperability, and to improve integration with our state's HIE.

The Health Care Payment Learning and Action Network (HCPLAN) has been an excellent platform for discussion and for synthesizing and disseminating ideas regarding front-line experience in State and Federal delivery system and payment reform. Arkansas's Medicaid Medical Director, Dr. Bill Golden, serves on HCPLAN's guiding committee, and has contributed too many of HCPLAN's publications which regularly include topics that mirror the activities occurring in Arkansas. Arkansas plans to continue to contribute important expertise in current and future efforts in the state, and strongly advises that CMS continue to look to HCPLAN for best practices and ideas regarding state-based interventions.

Arkansas has also maintained communication with the state's Round 1 SIM team at CMMI. This team has been helpful in guiding the Arkansas team through SIM expectations and providing technical support when needed. It will be optimal for Arkansas SIM team to maintain assistance from CMMI for future efforts and expansion of current SIM activities.

Arkansas has contributed official responses to prior CMS/HHS RFIs, including most recently the MACRA RFI on alternative payment models in November 2015. Arkansas welcomes the opportunity to provide comments and share insight in future CMS/HHS RFIs and rulemaking comment periods.

2. How can CMS/HHS better align in order to support state delivery system reform efforts?

It is important that CMS and HHS consider state efforts towards delivery system reform in the context of overall state resource allocation and financial investments, and complementary efforts to expand coverage or maintain access to coverage. As Arkansas seeks to operationalize the state's updated version of Medicaid expansion known as Arkansas Works, it is important for HHS to consider the efforts that Arkansas has undertaken with support from CMS and CMMI to increase the proportion of value-based care that is delivered in the state while improving quality and avoiding unnecessary costs. HHS should also continue to work closely with CMS to support delivery system reform across states and recognize state-specific challenges related to workforce, state-specific population health challenges and initiatives, and EHR use and HIE functionality.

**SPECIAL NOTE TO RESPONDENTS:** Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

**THIS IS A REQUEST FOR INFORMATION (RFI) ONLY.** This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, CMS is not seeking proposals through this RFI and will not accept

Unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publicly post the comments received, or a summary thereof.

# Connecticut Response to Center for Medicare and Medicaid Innovation

## Request for Information on State Innovation Model Concepts

### INTRODUCTION

The Office of the Lieutenant Governor of the State of Connecticut is submitting the following comments in response to Sections I and II of the CMMI, Request for Information on State Innovation Model Concepts.

### SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

1. A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation

#### **Questions**

- *What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?*

#### Medicare alignment

Connecticut is well on its way to implementing payment models that are broadly aligned with the Medicare Shared Savings Program model, recognizing that individual payers are tailoring their approaches to best fit with the Connecticut landscape and beneficiary challenges. Rather than engage with CMS on another large-scale multi-payer reform, we are seeking the opportunity to engage with Medicare to support alignment on a more incremental series of reforms intended to build the capabilities and business models to succeed under Advanced Alternative Payment Models (AAPMs).

Large scale Medicare demonstrations (e.g., the Maryland global budget initiative) often involve sweeping or foundational reforms that take years to plan and negotiate and which may be disruptive to existing reform efforts. Contrast this with state-based efforts to align commercial and Medicaid payers, which tend to occur iteratively, undertaking new projects over time rather than a single set of large scale reforms. Examples include alignment on insurance design components or a quality measure set for value-based payment.

We recommend that Medicare develop an approach that enables participation in targeted or project based alignment initiatives at the state level to enable Medicare to participate in state reforms that are evolutionary in nature. In Connecticut, there may be an interest in examining multi-payer reform of primary care payment methods within the context of over-arching SSP reforms. Medicare participation in such a reform is critical if primary care practices are to

change the way they do business. A willingness on the part of Medicare to review and implement small-scale or targeted alignment projects with commercial and Medicaid payers at the state level would be of considerable value in enabling our broader care delivery reform agenda.

#### Episode based Alternative Payment Models

Episode-based APMs have not been widely adopted in the Connecticut commercial market and Medicaid, perhaps in part because they are expensive to design, build and maintain, prohibitively so if one targets wide range of conditions and procedures. If all of Connecticut's payers pursue episode-based APMs independently, the lack of payer alignment will create an environment within which it may be impossible for providers to succeed. To our knowledge, Medicare is the only payer that is preparing to implement a large number of such APMs across a wide range of subspecialties, and they are doing so on a national scale such that the costs of development may yield a return on investment in time. (Our limited understanding of state generated episode-type APMs is that they have been expensive to develop for Medicaid and have not been widely adopted by commercial payers.)

CMS should consider whether and how the new reimbursement models for professional services under commercial and Medicaid could be aligned with those of Medicare. The primary purpose would be to examine how Medicare's episode-based APM reimbursement strategy could be efficiently extended to other payers, thus capitalizing on CMS' investments and infrastructure for their design and deployment.

- *CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies?*

#### Population Health 3.0 – Payment Reform

Connecticut applauds CMS' continued focus on population health improvement as a reform objective. Our SIM program has, among its aims, the development of solutions under the broad category of community health improvement that are not addressed by CMS current portfolio of reforms such as CPC+, MSSP, or Next Generation. These solutions take aim at the following issues, which for the most part are not addressed adequately in most Medicare payment reforms:

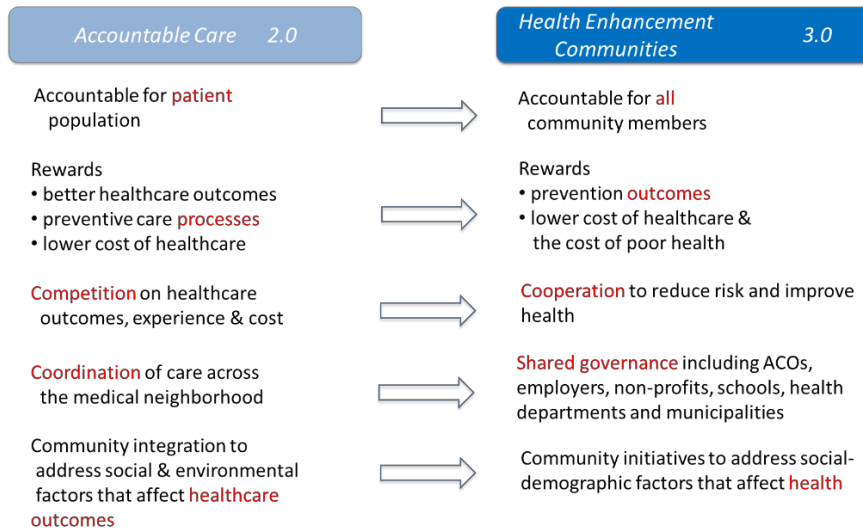
- The first issue is the need for a strategy for primary or secondary prevention, specifically, incentivizing reductions in the incidence and prevalence of acute and chronic conditions. The prevention or elimination of health problems tend not to be rewarded by today's accountable care models, most of which base their cost targets on the clinical risk of the population. Today's models have the advantage of 1-3 year return on investment cycles, rather than the 5-15 year cycles (or more) that are characteristic of prevention models. Under today's models, there is more of a financial opportunity



When one has more sick people on one's attributed panel, rather than less. If, in an effort to mitigate this problem, payers introduce disease prevalence measures onto payment scorecards or use an alternative market reference for costs projections, there could be adverse selection—i.e., an incentive to select healthier patients in an effort to improve disease prevalence scores or to reduce costs. Unfortunately, the latest Accountable Health Communities model perpetuates this problem by focusing on social determinants as a factor in healthcare outcomes, rather than primary and secondary prevention.

- The second issue is the problem of non-attributed populations—individuals who have not seen a primary care provider and instead go without care or seek care from an emergency department in the face of an urgent or emergent problem. Addressing the basic health problems of such individuals such as overweight and hypertension will remain out of reach unless this is called out as a primary aim for which our design must have a proposed solution.
- The third issue is the need to incentivize cross-sector collaboration, which might include the introduction of cross-sector rewards for addressing the above issues, especially when the needed solution lies outside of the direct influence or resources of a CCO. Housing code enforcement and food deserts are two examples. There are Connecticut health systems that have demonstrated that they can help drive these solutions, but it is not something that commonly occurs nor is it rewarded by today's healthcare market or emerging payment reforms.

Connecticut's SIM grant will not cover the costs to complete the design and implementation of a true [Public Health 3.0](#) model, what we refer to as a Health Enhancement Community model (see figure below). Accordingly, we would recommend that CMMI develop a third round of SIM funding focused entirely on promoting this next set of 3.0 category reforms. This opportunity must be coupled with meaningful strategies for Medicare participation, as was so effectively undertaken with the first two rounds of the SIM test grants. We are especially interested in, and have ideas for developing, models that promote cross-sector collaboration, build upon rather than disrupt the accountable organizations that have emerged under current payment reforms, and that take into account "long arc" return on investment timeframes.



### Population Health 3.0 – Quality Measures

Connecticut's measures of population health improvement are primarily derived from the BRFSS and, as such, are insufficient as the basis for performance rewards. These include measures of obesity/overweight, diabetes, asthma and hypertension prevalence as well as measures of smoking, diet and exercise. The state is seeking population health improvement process measures that would align with the CDC 6/18 initiative, especially diabetes and hypertension prevention and control. However, few NQF endorsed measures are available that meet this requirement. For example, we have not found any measures of pre-diabetes screening and follow-up, nor measures targeted toward intermediate outcomes that might be associated with evidence-based pre-diabetes interventions. CMS should consider stewarding directly, or working with the CDC and/or private foundations to fund the development of measures that correspond to our most widespread public health prevention challenges.

- *Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data?*

Connecticut is in the process of implementing its APCD. While this work is progressing, many payers are limiting their data submissions to fully insured products and, thus, it does not appear that the APCD will be of use for performance measurement for value-based payment purposes. We recommend federal action that would promote or require participation of ERISA exempt health insurance production in our APCDs.

In addition, it would be of benefit if CMS and ONC could continue to support efficient solutions for collection or reporting of eCQM, with an eye toward use in value-based payment. This might require continued evolution of CEHRT requirements related to eCQM to require the ability to produce panel-wide performance measures by attributed population. In the case of Connecticut, race/ethnic stratified reporting is an additional requirement. A certification or audit function will likely be required before payers will trust and adopt these measures for payment purposes.

There is a natural limit to the adoption of AAPMs, which is a result of the small number of lives attributed to some accountable organizations. CMS should consider challenging payers at the national level to adopt payment methods based on payer agnostic measures of performance (quality and efficiency), which would address the problem of small numbers. We commend CMS on promulgating a policy under which all-payer AAPM adoption is a measure of performance that qualifies for Medicare incentives, a move that is directionally consistent with rewarding all-payer measures of performance. A reasonable next step in this area would be to extend MSSP ACO-CAHPS performance measurement to an all-payer sample (with adjustments for payer mix), which could easily be extended to commercial and Medicaid shared savings program contracts.

## 2. Support states to align with existing Medicare models

- As note earlier, Connecticut's payers have developed payment models that are broadly aligned with the MSSP. The continued evolution of our payment reforms, however, needs to be tailored to the Connecticut context and, as such, we would ask that CMMI and CMS support customized and/or hybridized reforms that draw from but are not identical to those that Medicare has already introduced. For example, alignment with CPC+ as an alternative to MSSP type shared savings program contracts risks undermining the advanced networks that have emerged in Connecticut in recent years. This week, CMMI announced that it will re-open a solicitation to practices to join the CPC+ model for 2018. We would welcome the opportunity to examine whether elements of the CPC+ model could be applied to or paired with the MSSP model in order to better enable providers to be effective under this model. We would ask that CMMI permit and encourage MSSP participating practices to participate in these reforms, with existing SSP rewards serving in lieu of utilization based incentives. Any hybrid arrangement would need to provide a path toward recognition as an AAPM after the close of the SIM grant. (Note: The State has committed to stakeholders not to implement downside risk in Medicaid prior to the end of the SIM grant.)
- With respect to CPC+ and comprehensive primary care bundles, Connecticut providers have noted that the substantial increase in Health Savings Account (has) high deductible plans (24% of the commercial market by some estimates) would substantially limit take up of comprehensive primary care bundles because federal rules governing HSA plans preclude participation in comprehensive primary care bundles. This federal barrier needs to be addressed if multi-payer alignment around this approach is to gain traction. Similar barriers exist with respect to HSAs and value-based insurance design as described recently in a commentary by the [Journal of the American Medical Association](#).
- While CMS' overall focus on migration to AAPMs is clear, providers express considerable confusion about how best to take advantage of the confusing array of CMS and CMMI led reform opportunities that have emerged in recent years, culminating in the QPP under MACRA. In the view of some Connecticut stakeholders, many of the latest CMS and CMMI opportunities appear to be competing or in direct conflict. In order to help ensure successful implementation, we request that CMS provide more opportunity for state specific discussion and engagement on high-level strategy, especially as it relates to the interplay of various reform initiatives and the development of capabilities to ensure success. We recommend state specific discussions because state landscapes vary enormously. While the RFI process is a good start, we would

Encourage CMS to provide for an ongoing collaborative process, including the joint development of state-specific strategies, goals and measures.

- CMMI's strategy for supporting states also needs to consider the time and resources that it takes to develop the capabilities necessary to be successful in a reform environment, a process that has been hampered by EHRs that lack essential inter-operability and challenges in accessing and exchanging data. SIM funded transformational support has been important, but is time limited. Additional opportunities to support investments in care delivery reform should be made available as an adjunct to the continued focus on payment reform. The PTN opportunity was well received in Connecticut and appears to be a promising strategy. However, it was disappointing that such assistance was not made available to enable the success of our small to mid-sized ACOs. We recommend that CMMI consider strategies for enabling participants in MSSP rather than supporting mutually exclusive pathways to advancement. We recognize that this may make it difficult to meet evaluation requirements and in some cases present a risk of duplication; however, such requirements should not stand in the way of launching mutually enabling initiatives. We cannot afford to have a large number of providers that are participating in good faith in payment reform initiatives to lose interest or fail.
- We would request that CMS consider whether the process of granting waivers or undertaking state/federal partnerships could be streamlined and better aligned between Medicare and Medicaid. Ideally, it would be possible to develop and submit to CMS an over-arching plan for multi-payer payment reforms and to negotiate the Medicare and Medicaid related commitments and approvals through a unified process.
- To the extent reforms require Medicare alignment, we suggest streamlining access to Medicare Data to increase our chances of success.
- Achieving true multi-payer alignment depends upon engagement of employer sponsored plans. We suggest that USDOL be brought into discussions in order to engage employers and third party administrators to ensure true multi-payer alignment.

# Disability Advocates Advancing Our Healthcare Rights (DAAHR)

October 28, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Blvd.  
Baltimore, MD 21244

Submitted electronically to: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov).

Re: Request for Information on State Innovation Model Concepts

Dear Acting Administrator Slavitt:

Disability Advocates Advancing Our Healthcare Rights (DAAHR) respectfully submits the following comments regarding the request for information on State Innovation Model Concepts. DAAHR is a Massachusetts coalition of disability, elder and advocacy groups in Massachusetts. Led by the Disability Policy Consortium (DPC) and the Boston Center for Independent Living (BCIL), we are deeply involved in healthcare advocacy in Massachusetts, including, though not exclusively, on the One Care demonstration and the 1115 waiver. Our leadership consists of people with disabilities and other populations that use Long-Term Service and Supports (LTSS), recovery services, social and other services necessary for people with complex needs to live quality lives in the least restrictive settings of their choice. DAAHR is particularly concerned about the rights of people with complex physical, mental health, substance abuse and/or cognitive service needs— those most at risk of harm because of thin margins of health and many unmet needs. DAAHR supports consumers' ability to control their care team composition, the determination of their healthcare goals, control and choice of their service providers, and where services are received and how those services are provided.

DAAHR has worked closely on the development of One Care and appreciates the potential benefits that can be afforded people with disabilities in the state through Accountable Care Organizations (ACOs). We recognize the tremendous need to improve healthcare access and outcomes for the population in a resource-effective manner. DAAHR collaborates with Community Catalyst, Health Care for All, Justice in Aging and other national groups as well as grassroots organizations in other states. DAAHR also works collaboratively with health plans, hospitals, SEIU and provider organizations to promote positive working relationships that move the system forward in a sustainable as well as a just and consumer responsive manner.

DAAHR appreciates the opportunity to offer strong consumer voice to considerations being made by CMS in shaping the direction for the State Innovation Model (SIM) program. While we support the effort of CMS to provide care coordination and integration, we are concerned that plans, providers and service delivery systems lack the cultural competency and/or capacity to

Meet the ambitious timetables and goals set out by CMS. In addition to lack of competency and capacity, the science of measuring quality of LTSS and other services needed by people with physical, mental health, substance abuse, cognitive and chronic conditions are still in development. In particular, we are lacking quality metrics that reflect consumer definition of wellness and quality of care. DAAHR urges CMS to re-examine its path for fully implementing payment models aligned with the Quality Payment Program to ensure that appropriate quality metrics are in place to measure the impact of QPP on consumers with complex medical and community needs. This will require an ongoing commitment by CMS to consumer involvement in leadership activities for moving QPP at the state and national level.

## **SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

*a. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?*

### Population-based APM and MIPS

APMs and MIPS, if not population appropriate, can harm people with disabilities and others with complex needs. ROI targets should not drive APMs or MIPS. CMS needs to build guide rails to prevent inappropriate use of APMs and MIPS moving forward, particularly if there are plans for integration of LTSS and behavioral health costs. If ROI shapes the new QPP, states and ACOs may seek to reduce cost of LTSS by reducing PMPM contracting arrangements with entities that coordinate and/or provide LTSS to consumers. They may also seek to “bundle” LTSS, HCBS, recovery and habilitative service that prioritizes ROI rather than quality of life and increased opportunity for participation in the community as well as employment. Bundled payments in themselves can be harmful for people needing inpatient rehabilitation services and for those people with complex chronic conditions requiring ongoing intensive care.

### Equitable Access to Services across Payers

DAAHR is particularly sensitive to the need for CMS to build equitable access into its Medicare alignment goals. We are dismayed that as put forth, the 1115 waiver application by MassHealth exacerbates, rather than reduces, inequity in access to services across payer and plan models. Medicare enrollees in Massachusetts dual plans (One Care and SCO) have access to expanded LTSS with no copayments for any type of medical or other services. The services provided to a member will be determined by the member in coordination with his or her care team. Populations with like the same healthcare and LTSS needs, if enrolled in a capitated ACO, have prior authorization conducted within the ACO, but the member will be denied access to enhanced LTSS and have to pay out-of-pocket expenses. If in the fee-for-service system, or on-capitated ACO, people in this population will be required to pay out-of-pocket expenses and

have prior authorization for LTSS conducted by an external Third-Party Administrator (TPA). The TPA is not responsible for improving quality of LTSS as required of dual plans and ACOs.

Providers may also cherry pick members to avoid populations needing high levels of complex care to avoid facing APM and or MIPS financial penalties. Without a commitment by CMS to a system of QPP that is equitable for the consumer as well as the provider, health care will continue to be provided in a manner that leads to continued inequity in access to quality care and services at the population level. DAAHR requests that CMS take into consideration all the variables that impact health outcomes of the poorest and most vulnerable consumers, who, because of thin margins of health and other factors such as race, ethnicity, immigrant status, and other social determinants might be negatively impacted by the alignment strategy.

### Consumer/Consumer Voice

We believe CMS must require states to put in place vehicles for strong consumer perspective and voice comparable to the Consumer Advisory Board (CAB) model established in Connecticut. DAAHR also believes is important that CMS, in its final policies, include mechanisms that support processes, such as those that produced the Massachusetts One Care Implementation Council. The model only came about as a result of more than a year of ongoing intensive collaboration and negotiation between DAAHR and MassHealth. This is also true of the ombudsman program in Massachusetts for One Care. There was strong CMS support throughout for efforts to design these vital consumer protection elements.

It is important that CMS recognize that robust consumer voice is only possible when states invest resources into consumer involvement. This includes subsidizing transportation costs and remuneration for consumer time and involvement in meeting preparation, and other activities, in addition to meetings themselves. This is particularly important for lower income consumers from underserved populations and/or populations with high levels of medical need. In addition, states need funding to conduct appropriate outreach and related activities to ensure involvement of a wide spectrum of consumers in state health reform activities.

### Electronic Medical Records

All medical portals should comply with Americans with Disabilities Act and other federal accessibility standards, with CMS setting a baseline that states can surpass, but at a minimum must meet. In analyzing EMR needs, it is important that CMS take into consideration the overall IT structure required for effective system wide communication of consumer information to take place. It is also imperative that IT infrastructure and information sharing include provisions that protect the privacy rights of consumers, particularly those with lived experience of a psychiatric diagnosis or substance abuse, as well as other populations, including consumers identifying as GBLTQ, those having records of involvement in the criminal justice system, and others with diagnoses that might result in discrimination or stigma, including HIV/AIDS.

***d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation?***

DAAHR is concerned that without the appropriate safeguards and financing approach, economic pressures will result in a reduction of medical services for people with complex needs. Without appropriate protections in place, QPP could result in a reduction of continuity of care and reduced competence of care. This may occur as a result of APM or MIPS contracting agreements created to drive down prices, along with “out of network” policies that will restrict and reduce consumer choice and access to providers with specialties in specific diagnoses or conditions such as Multiple Sclerosis, Huntington’s Disease, closed head injuries, among many. This same concern exists in the provision of care for people with intellectual disabilities and people with behavioral health needs, particularly people with severe persistent mental illness.

DAAHR is concerned that the opportunity to reform the healthcare system through QPP will be lost to an emphasis on cost reduction and market forces. In Massachusetts, for example, we are extremely concerned about protecting enrollees in the Senior Care Options (SCO) and One Care (OC) programs and the potential for QPP to interfere with SCO and OC models, especially provider networks and access for enrollees. The SCO and OC programs were created by the state and federal government to serve the best interests of elders and people with Medicaid and Medicare. CMS must put forth protections to prevent QPP from causing reductions in network capacity for SCO and OC enrollees.

***g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?***

DAAHR recognizes that the fee-for-service system as it currently exists is broken, especially for many people with complex healthcare and LTSS needs. And while we support systems alignment and content, we do not believe that CMS has outlined an alignment model that adequately protects vulnerable populations with complex needs from harm. We urge CMS to slow its current process down and take into consideration the broader, negative, implications of alignment that can result from an emphasis on a reduction in cost without appropriate attention to population-based outcome measures. This requires a reexamination of APM and MIPS and the goals of QPP.

It is further requested that CMS increases its emphasis on consumer engagement and development of process and outcome metrics that measure states’ commitment to inclusion of consumer voice. This includes commitment to equitable access to services across payers.

Thank you again for the opportunity to comment on the alignment process. Please contact us if you have any questions.



Sincerely

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***Comments in Response to:  
Center for Medicare and Medicaid Innovation Request for Information on State  
Innovation Model Concepts***

***Submitted by: Ana  
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The Center for Improving Value in Health Care (CIVHC) would like to thank CMS for the opportunity to provide feedback to inform future innovation.

CIVHC is a non-partisan, non-for-profit organization that administers the Colorado All Payer Claims Database (CO APCD) through appointment by the Colorado Department of Health Care Policy and Financing (HCPF). The CO APCD is a secure database currently containing over 560 million health insurance claims from 23 commercial health insurance companies, Medicare Fee for Service (FFS), Medicare Advantage plans, and Medicaid. CIVHC represents the perspectives of varied health care stakeholders to achieve its mission of supporting initiatives working to advance the health care Triple Aim: better health, better care and lower costs.

As noted in the Request for Information (RFI), CMS recognizes the critical role of data to support the state and federal level programs working to advance delivery system redesign and transform payment for health care. As states invest resources and energy in the transformation efforts through CMS and other organizations, data at the state and local level will be essential to inform and evaluate these initiatives. We will be responding to selected questions from the RFI in our role as CO APCD administrator and key partner in the Colorado State Innovation Model, the Colorado Transforming Clinical Practice Initiative, and other initiatives.

CIVHC's comments will be focused on the expressed desire from CMS to understand the state-level data infrastructure and capabilities required to support ongoing work to transform healthcare in Colorado. Our comments will address question 3, parts a, b, d, e, f, and h, from Section I: Multi-Payer State-Based Strategies to Transition Providers to Advanced Alternative Payment Models.

Question 3:

“Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.”

- a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?

The Colorado APCD began operations in 2012 with historical claims data for the period 2009 through 2011 from the largest 7 commercial payers plus Colorado Medicaid. Since that time, we have expanded to include claims data submissions from more than 20 payers, including Medicare FFS, Medicare Advantage plans, Medicaid, and commercial payers, as well as pharmacy and dental claims data.

Payers, with the exception of Medicare FFS, are required by statute to send monthly eligibility, provider, medical, pharmacy and dental claims updates to the CO APCD, which are then processed and updated to the CO APCD warehouse every quarter. Our current reportable data lag is approximately six months from date of service. This will be changing to approximately 3 months mid 2017 as we move to monthly CO APCD warehouse updates. Medicare FFS data lags significantly behind the commercial and Medicaid data, with lag between service and CO APCD reporting accessibility of approximately 12-18 months.

The comprehensive data available in the CO APCD gives us the unique ability to combine claims data for multi-payer benchmarking and reporting as the data becomes available. The enabling statute for the CO APCD requires that recipients of any data set or report from the CO APCD be evaluated to ensure that the purpose of the data release is to benefit Coloradans and advance the Triple Aim. This includes the full array of health care stakeholders including our state and federal partners, payers, providers, employers, and consumers as well as university and hospital researchers, and private partner organizations. Medicare FFS data use is limited according to the State Research Data Use agreement and Qualified Entity allowable uses.

Additionally, CIVHC has been a participant in Phases 1 and 2 of the Network for Regional Healthcare Improvement (NRHI) led Robert Wood Johnson Foundation funded work: *Evolving the Regional Total Cost of Care Project and Demonstrating Preparedness for National Scalability*. With partners Maine Health Management Coalition, Midwest Health Initiative, Minnesota Community Measurement, and Oregon Health Care Quality Corporation, this project aims to leverage health care cost data to produce standardized measures of total cost of care and resource use at the primary care physician practice level. The ultimate goal is to identify drivers and highlight specific opportunities to reduce costs and improve care for physician practices regionally as well as nationally.

The work from this grant focuses on data from commercial payers, but CIVHC hopes to leverage the methodology to create reliable and consistent comparative measures of the total cost of care for all payers, including Medicare and Medicaid.

- b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-

Payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?

CIVHC provides population health measures and de-identified aggregate data publicly on its site [comedprice.org](http://comedprice.org). This includes cost and utilization data and measures as well as chronic disease prevalence and prevention information along with readmissions, ER visit rates and percent generic scripts by county, three digit ZIP code, and CO Health Statistics Regions. Currently, the public reporting is limited to commercial and Medicaid with Medicare planned for release in 2017 along with a broader set of quality, cost and utilization measures.

As part of our work with the State Innovation Model, CIVHC has developed more than two dozen claims-based population health measures that can be generated for any single or multi- payer population. Some of these measures are currently being used to support CO SIM practices and to report on progress and success to CMS. While the measures are limited to claims at this point, we look forward to collaborating with other data sources to create more robust and actionable measures in the future.

CIVHC is currently working to develop that capability by partnering with its stakeholders across the state and nation to develop alignment and integration capability with other data sources such as health information exchanges, state vital statistics, cancer and immunization registries, clinical data and others.

Due to variation in billing and coding practices at clinics and clinical practices, we do not currently have the ability to accurately report down to the individual provider level. Group or practice level reporting is regularly used to support state and federal programs, but the challenges of accurately separating billing and servicing provider within those groups have kept us from more granular reporting. We hope the work to align and integrate clinical information with the claims data will support the ability to report cost, utilization, and outcomes on an individual provider level.

One of CIVHC's programs is working with more than 60 hospitals, providers, payers, and community-based organizations to create the capability to track social services data that can be aligned with both clinical and claims data to create more comprehensive tracking of outcomes and drivers of health and health care costs. The progress on this project has been rapid and we anticipate first steps towards implementation within the next year.

- d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?

Unlike the majority of APCDs in the country, CIVHC does not receive operational funding from the state to support the CO APCD operations, maintenance or utilization. As a result, CIVHC operates with a minimal, yet highly efficient staff and must charge requestors a data-licensing

Fee to cover the cost of managing the CO APCD, fulfilling data and analytic requests, developing and implementing new reports and public reporting. Much of our data aggregation and clinical outcomes measurement ability relies on long-term positive relationships with stakeholders such as the University of Colorado, Children's Hospital of Colorado, and the State of Colorado, who all work to integrate different data sources for specific researcher analytic projects.

In support of the Comprehensive Primary Care Initiative and its successor, CPC+, CIVHC supplies claims data to Best Doctors for claims and clinical data aggregation and reporting to participating providers through their STRATUS tool. As opportunities and funding for infrastructure development becomes available, CIVHC and the State would like to create aggregation capacity within the state and eliminate the need to contract with private outside entities. This capacity will require a significant investment of time and funds, but will create a critical resource for providers, practices and payers that will support the development and implementation of new payment models and delivery system innovations.

e. What support can CMS provide to improve states' access to reliable and timely data?

There are several elements that would improve Colorado's access to reliable and timely data to support transformation:

- Increased submission frequency of Medicare Fee for Service data to align more closely with the monthly submissions of commercial and Medicaid payers. Currently, access to Medicare Parts A and B data lags behind commercial plan and Medicaid claims data by up to 12 months.
- Increased submission frequency of Medicare Part D data to align more closely with the Reporting of clinical data. Currently Medicare Part D data is at least 18 months behind our commercial and Medicaid pharmacy claims due to annual adjudication. This significantly delays fully integrated Medicare/Medicaid or Medicare/Commercial (Medicare Advantage) claims and creates barriers to effective evaluation of pilots and other innovations.
- Enabling submission of TriCare, VA, IHS, Federal Employee Health Benefits and other federal health insurance data on a national scale. Colorado has the largest population of federal employees outside of Washington DC, as well as a robust veteran population and two large Ute Indian reservations. The lack of this federal level health data has a significant negative impact on the completeness of our data – both claims and clinical, and prevents those populations from readily benefitting from payment and delivery system innovations. Our local partners are eager to collaborate with us, but collaboration on a facility by facility basis is inefficient and inconsistent.
- Ongoing support and encouragement of rapid development and acceptance of the Common Data Layout, being created by APCDs across the country and the Department of Labor as a result of the Supreme Court decision in *Liberty Mutual v. Gobeille*. The national acceptance of the Common Data Layout will pave the way for the integration of self-funded commercial plans into APCDs.

- f. How can CMS support improved access to and linkage with health outcomes measures data?

The primary obstacle to functional and effective linkage with health outcomes data is a lack of funding to develop the infrastructure required for accurate and efficient alignment of claims data with health outcomes measures.

The State of Colorado, CIVHC, and Colorado's Health Information Exchanges are currently working on a proposal to create Master Patient/Provider Indices that would allow for accurate alignment of available data from diverse sources. The planning for this effort has just begun and the required resources have not yet been established. All of the involved organizations have the ability to complete this work, but the lack of resources to create the infrastructure necessary for alignment is an enormous barrier to implementation.

A need for a uniform clinical data standards format is critical to the widespread adoption of fully integrated HIE and to increasing the ability to combine clinical information and health care Claims data.

- h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?

As mentioned in our response to part f, while there is significant interest, capacity and ability, the lack of infrastructure for data alignment is a significant barrier to generating the integrated data necessary to support transformation efforts.

Each of the data entities in the state has the ability to securely extract and transport data to authorized users, but the alignment of those extracts is problematic. The various Colorado data sources also have significant analytic capability, especially when partnering with research organizations like the University of Colorado, though aggregating that data continues to be problematic. The CPCi aggregation work done by Best Doctors was an solid start towards developing data alignment between certain data elements, but as a private, for profit entity, there is limited sharing of the methodology they used to accomplish that aggregation, making any attempt at replication by public organizations costly and time-consuming.

In conclusion, there is enormous potential for expansion and alignment of Colorado's data sources, and that expansion could prove crucial for ongoing work to transform health care to improve care and reduce costs. We encourage CMS to continue working with states to determine the critical next steps in data alignment and integration, and look forward to supporting CMS in their ongoing efforts to encourage state-level transformation of the delivery and payment systems. We are happy to answer any additional questions or provide additional information if desired.

**Association of State and Territorial Health Officials**

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October 28, 2016

The Honorable Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services Attention: CMS-3323-NC  
Submitted electronically at: <http://www.regulations.gov>

Re: Request for Information on State Innovation Model Concepts

Dear Acting Administrator Slavitt :

The Association of State and Territorial Health Officials (ASTHO) appreciates the opportunity to submit comments regarding this Request for Information (RFI) on next steps for the State Innovation Models (SIM) initiative under the Center for Medicare and Medicaid Innovation (CMMI). This RFI was published by the Centers for Medicare & Medicaid Services (CMS) in September 2016.

ASTHO is the national nonprofit organization representing the state and territorial public health agencies (S/THAs) of the United States, the U.S. Territories, and the District of Columbia. ASTHO's members, the chief health officials of S/THAs, are dedicated to formulating and influencing sound public Health policy, and to assuring excellence in state-based public health practice. S/THAs play a critical part in improving population health in their state - they assess community needs, design, implement and evaluate programs that prevent or mitigate disease or injury, work to reduce health disparities, identify best practices, and evaluate impact, as well as convene and collaborate with stakeholders and communities. In addition, ASTHO's members have a range of responsibilities and relationships with their State Medicaid agency: ranging from statutory oversight, membership in an umbrella agency, or reporting separately to the Governor or other executive.<sup>1</sup> Thus, S/THAs have a unique role in payment and delivery reform efforts and activities that improve population health.

ASTHO and its members are appreciative of the opportunity to provide information and feedback on potential next steps of the SIM initiative. Many S/THAs have been engaged in SIM Rounds 1 and 2. While state and territorial health officials and their public health staff may be part of cross-agency planning and testing teams, there is significant variability among the states on the leadership and expert information that they are providing to these teams. In some cases, the S/THA may have served in a governance role, be actively leading various subcommittees, and/or be well integrated into the decision-making processes such as defining health priorities and metrics. In comparison, they may be more of a passive participant contributing in a very limited way on discrete public health topics in other states.

**Given S/THAs' leadership and expertise in population health and prevention, it is our hope that in future SIM efforts both the structure of the new opportunities and guidance from CMMI would**

<sup>1</sup> In six states, the state health official (SHO) has statutory oversight of Medicaid (Kansas, Maryland, Montana, New York, and Utah); in 14 states, the state health agency (SHA) and Medicaid are part of an umbrella agency, and in 31 states and DC, the SHA and Medicaid report separately to the Governor or in DC, to the Mayor.

**require and encourage greater engagement of and collaboration with S/THAs in these transformation activities.**

SIM Rounds 1 and 2 have been excellent opportunities to strengthen the capacity and infrastructure of states to pursue payment and delivery reforms. This funding has allowed states to enhance existing efforts and support other activities related to value-based payment reform, including information technology and exchange. Specifically, ASTHO and other state health organizations have heard from S/THAs that SIM funding has facilitated stakeholder outreach, collaborative learning activities, technical assistance, and investments in infrastructure.<sup>2</sup> S/THAs have also expanded the lens of health to engage a greater number of partners in establishing accountability for a community's health.

As such, ASTHO and its membership enthusiastically support additional SIM funding to continue infrastructure development and applaud CMS' consideration of the potential alignment of future SIM funding and ongoing state demonstrations with Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and other federal payment and delivery reforms. States across the country are already leading reform efforts that are moving towards value in the healthcare system in their Medicaid programs, while meeting the needs of the diverse populations they serve. In fact, a recent study by colleagues at the National Association of Medicaid Directors (NAMD) found that almost two-thirds of the 34 states surveyed had implemented or were planning to implement alternative payment models (APMs) that rewarded value over volume.<sup>3</sup> Aligning efforts between Medicaid programs and Medicare further expands the impact of these activities and reduces burdens on providers.

The complex and ever-changing reform landscape, which includes Medicaid expansion, waiver programs, managed care and patient-centered medical home reforms, Comprehensive Primary Care Plus (CPC+), and now MACRA, can be challenging for S/THAs to coordinate and manage.<sup>4</sup> Thus, federal guidance and consideration of alignment between SIM, MACRA, and other reforms is needed and supported to help inform states' efforts. This guidance should be provided with input from states themselves to identify areas for technical assistance, clarification of policies, and greater attention. In particular, clarification is needed about how Medicaid programs can be certified as Advanced APMs

<sup>2</sup> National Academy for State Health Policy. "A Federal-State Discourse on Maintaining Momentum for Payment and Delivery System Reform." September 2016. Available at: <http://nashp.org/wp-content/uploads/2016/09/Discourse-Brief.pdf>. Accessed 10-11-2016.

<sup>3</sup> National Association of Medicaid Directors. "NAMD Comments on Medicare Program." June 27, 2016. Available at: <http://medicaiddirectors.org/wp-content/uploads/2016/06/NAMD-Final-Comments-on-MACRA-6-27-16.pdf>. Accessed 10-12-2016.

<sup>4</sup> With the complexity of health systems transformation and other reforms, states and engaged stakeholders face a number of challenges. In a 2014 survey of state health agencies, ASTHO found that for both SIM and non-SIM payment and delivery system reform, respondents (n = 47) indicated that "differing perspectives on which steps to take" was the biggest barrier to planning. In terms of implementation, "not having enough resources" was the biggest barrier for SIM activities, while "challenges related to workforce" and "differing perspectives on which steps to take" presented the greatest barriers for non-SIM payment and delivery system reform. Additional reported barriers included political challenges, turf issues, challenges with payers, reaching consensus on an integrated model, and finalizing approved plans. Source: <http://www.astho.org/Health-Systems-Transformation/Payment-and-Delivery-Reform-Activities-Issue-Brief/>.



would be extremely beneficial to states.<sup>5</sup> Moving forward, ASTHO supports CMS' alignment efforts and recommends that both high level and detailed guidance would be extremely helpful, such as reporting requirements, metric development and methodologies, and messaging.

As alluded to in the RFI, ASTHO agrees with CMS that data systems and infrastructure are a crucial and foundational part of payment and delivery reforms. With SIM funding, as well as other investments, states are developing interoperable systems, including All-Payer Claims Databases (APCDs). Despite progress made over the last several years, there is an incredible amount of work left to be done to ensure that different systems, including legacy databases, are leveraged to provide actionable data for decision making and identify areas to target for interventions. We recommend that CMS and CMMI work with our partners at the National Association of Health Data Organizations (NAHDO) and SIM states to identify and share effective practices in utilizing statewide APCDs for measurement, benchmarking, and evaluation of health reform initiatives. Leveraging APCDs reduces reporting burden on individual physician practices and permits a broader view of health care delivery system performance. States welcome support from CMS to address key information gaps, including substance abuse data (e.g., 42 CFR Part 2) and Medicare Advantage data. In addition, from our public health perspective, maintaining support for enhanced public health reporting through the Merit-based Incentive Payment System (MIPS) and other programs, as well as encouraging programs such as electronic case reporting, are important to promote linkages between public health and healthcare to improve population health.

Beyond developing the data infrastructure, measures associated with payment and delivery reforms should be informed by the state or territory's health priorities identified in their State Health Assessments and State Health Improvement Plans. This linkage would allow for alignment of state public health accreditation with payment and delivery reform, to increase synergy with other activities ongoing in the state.

With regards to testing specific care interventions, ASTHO is supportive of funding to support interventions that focus on priority conditions on populations; however, would caution that many states have different priorities given the populations they serve and would need flexibility to adapt the model to their specific context. Thus, randomization may not be possible, although it is challenging to provide further input on reporting and program structure absent guidance on what specific care interventions are to be tested. Potential care interventions to be tested should not be limited to adults with chronic disease and consider other populations of focus. Interventions for further consideration include:

- Integrating behavioral health and primary care.
- Use of community health workers or health extenders.
- Interventions targeted at children and youth with special healthcare needs.
- Interventions or policy changes that provide reimbursement for preventative services delivered by nurses, social workers, pharmacists, and nutritionists that improve population health (e.g., Nurse-Family Partnership; diabetes self-management education, and medication therapy management)

<sup>5</sup> National Association of Medicaid Directors. "NAMC Comments on Medicare Program." June 27, 2016. Available at: <http://medicaiddirectors.org/wp-content/uploads/2016/06/NAMC-D-Final-Comments-on-MACRA-6-27-16.pdf>. Accessed October 12, 2016.

**Association of State and Territorial Health Officials**

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However, these interventions or policy changes would likely need at least three years or more before they could be evaluated. In addition, it is worth noting that states are already making significant progress on specific care interventions, including the [Million Hearts initiative](#) and the CDC's [6/18 Initiative: Accelerating Evidence into Action](#), through which state public health agencies are working with their state Medicaid agencies to implement proven interventions to address six common and costly health conditions. Supporting ongoing efforts to enhance partnerships between Medicaid and public health on specific care interventions would help accelerate this work.

For both sets of activities described in this RFI, ASTHO recommends that CMMI work closely with its other federal agency partners, and in particular, the CDC. The CDC provides significant funding to support S/THAs activities on different conditions and requires different surveillance reporting to minimize inefficiencies and reporting burden on state health agencies. Further, technical assistance available to states should be coordinated between both CMMI and CDC to support infrastructure and workforce development, as well as coordinating on different ongoing initiatives that encourage healthcare payers and providers to consider the social determinants of health and interventions that focus on upstream factors (e.g., Accountable Health Communities), to avoid demonstration fatigue.

One question that arose during consideration of this RFI among ASTHO staff and state health officials who provided input was about how states who had not yet participated in SIM would be affected by a potential Round 3. States may have chosen to not participate in SIM due to a lack of gubernatorial support or other factors. However meeting states where they are, including those who are still in the early stages of payment and delivery reforms, is needed to ensure that all states have opportunities to develop the infrastructure necessary to support health systems transformation.

In conclusion, we believe that S/THAs can and should play a larger role in health systems transformation and payment and delivery reform, given their expertise in evidence-based interventions, working with vulnerable communities, engaging non-traditional partners, and evaluating population-based outcomes. Should you have questions or comments or require additional information, please contact Megan Miller, Senior Director, Health Integration at [mmiller@astho.org](mailto:mmiller@astho.org) or 202-371-9090 ext. 5421. We look forward to continued collaboration and dialogue.

Sincerely,



Jay Butler, MD

President, Association of State and Territorial Health Officials

Chief Medical Officer and Director of Public Health, Alaska Department of Health and Social Services

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cc:

Michael R. Fraser, PhD, CAE, FCPP  
Executive Director, ASTHO

Stephen Cha, MD

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***Comments in Response to:  
Center for Medicare and Medicaid Innovation Request for Information on State  
Innovation Model Concepts***

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The APCD Council commends CMS for providing an opportunity to provide feedback to inform the planning for possible future State Innovation Model (SIM) projects.

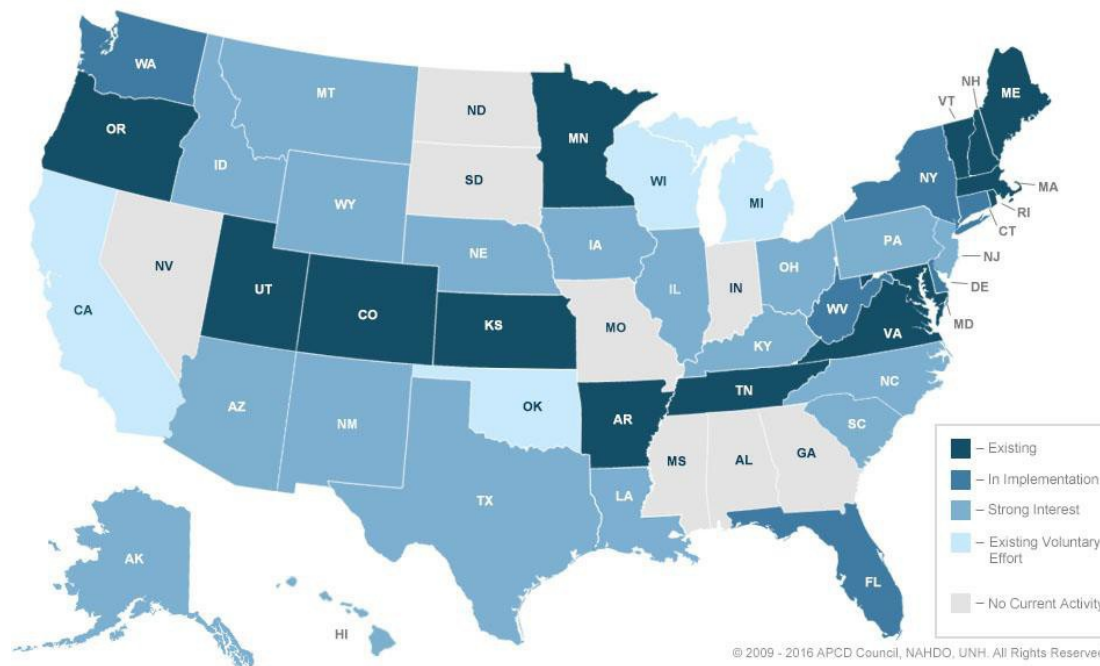
The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

As noted in the Request for Information (RFI), “CMS has set ambitious goals for health system transformation, and we recognize that much of this transformation will ultimately occur at the state and community level. Our investment in SIM is a recognition of the important role states play as a locus for change to accelerate transformation, and their unique leverage point to implement models consistent with the proposed Quality Payment Program under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation.” As states invest resources and energy in the transformation efforts that are part of SIM and other state initiatives, the need for data at the state and local level data will be essential in order to inform and evaluate transformation efforts. It is with this data lens that we developed this response to the RFI.

The APCD Council comments are focused on CMS' interest in understanding the necessary data infrastructure at the state level to support transformation. Specifically, the comments address the questions posed in "SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS, question 4: "Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data."

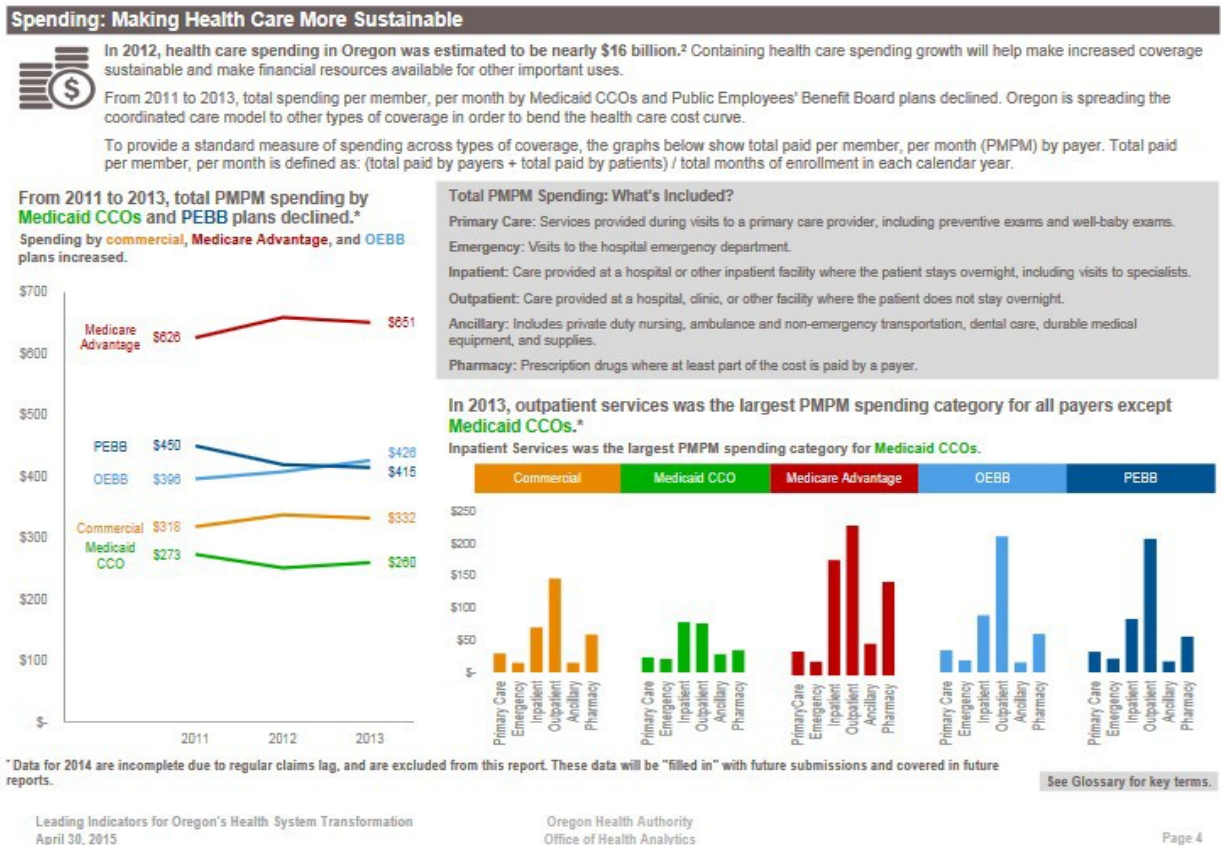
*3a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?*

Currently, 19 states currently have or are implementing APCDs (see the map below). Statewide APCDs are: Databases, typically created by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. With this breadth of data collection, states with APCDs will have access to multi-payer claims data that can provide the benchmarks and monitoring of trends for Medicare, Medicaid, and commercial populations.



Examples of how states have been able to use the APCD for benchmarking and monitoring include:

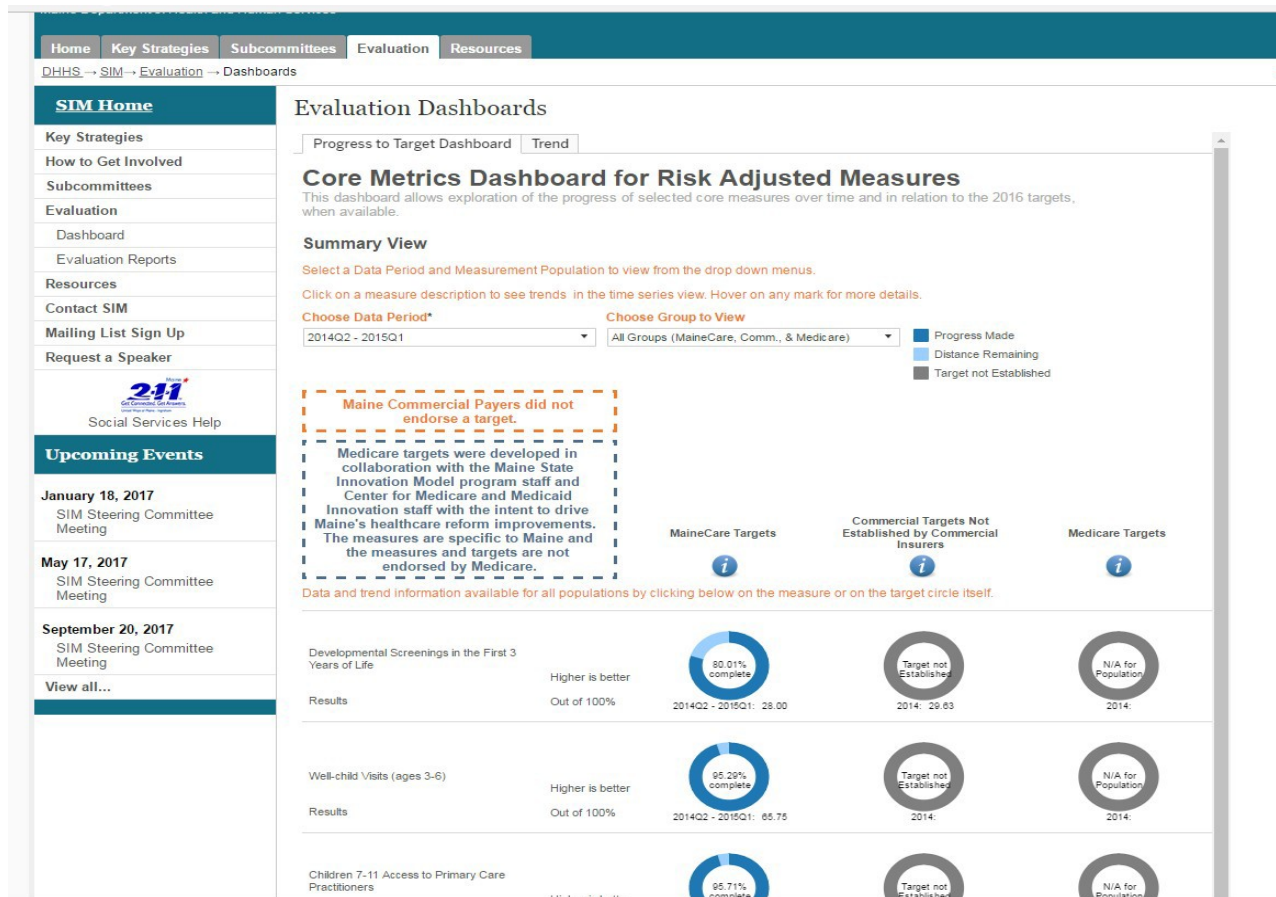
**Oregon:** The Oregon Health Authority published a report that provides comparisons of Per-Member Per-Month costs, by service category, for commercially insured, public employees, and public payers. This report has been developed as part of the reporting to support Oregon's Health System Transformation effort (<http://www.oregon.gov/oha/analytics/APACPageDocs/Leading-Indicators-Report-April-2015.pdf>).



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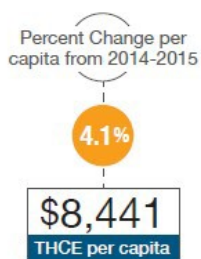


**Maine:** The State of Maine has used its APCD data to develop dashboards to support its SIM efforts, providing benchmarks across many key metrics (<http://www.maine.gov/dhhs/sim/evaluation/dashboard.shtml>).



**Massachusetts:** The MA Center for Healthcare Information and Analysis (CHIA) develops an annual report of health care costs and expenditures by population, types of service, and geography to support its larger system transformation effort statewide (<http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report-rev-1.pdf>).

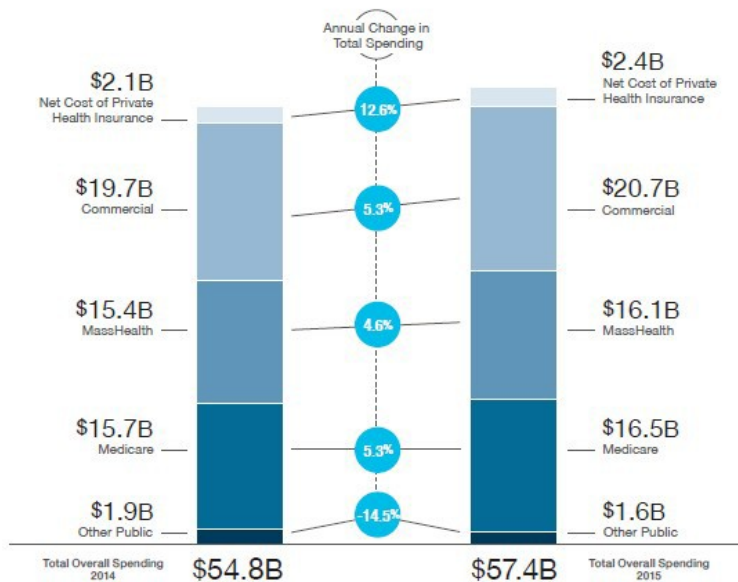
**HEALTH CARE EXPENDITURES  
PER MASSACHUSETTS RESIDENT  
WERE \$8,441 IN 2015—AN ANNUAL  
INCREASE OF 4.1%.**



Source: Payer-reported data to CHIA and other public sources. See [technical appendix](#).  
Notes: Percent changes are calculated based on non-rounded expenditure amounts. Please see [databook](#) for detailed information.

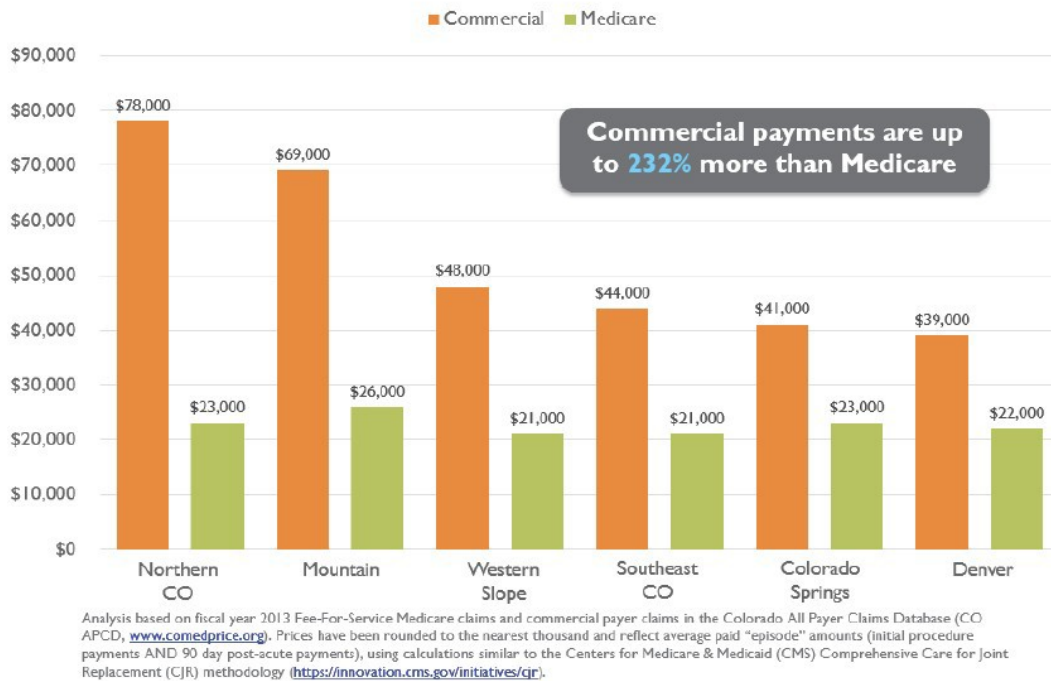
**2 Components of Total Health Care Expenditures, 2014-2015**

THCE represents the total amount paid by or on behalf of Massachusetts residents for insured health care services. It includes the NCPHI (non-medical spending by commercial health plans), and medical spending for commercially and publicly-insured Massachusetts residents.



**Colorado:** Among the analysis and reporting from the Center for Improving Value in Health Care (CIVHC)'s reporting are comparisons of costs for commercial and Medicare for common health care services (<https://www.comedprice.org/#/home>).

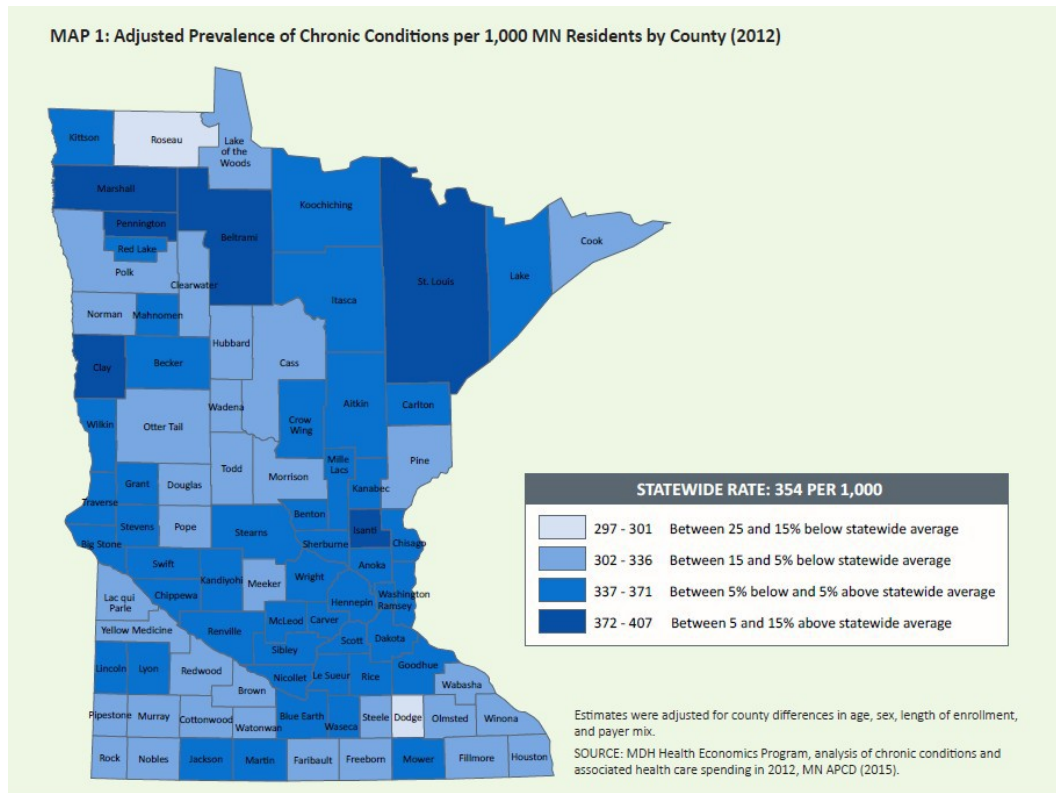
## Colorado Hip/Knee Replacement Average Total Episode Payments Medicare vs. Commercial





**Minnesota:** The State of Minnesota recently published a report focused on the prevalence and cost of chronic conditions in the state, providing comparison for populations with different disease profiles and by geographic region

([http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/20160127\\_chronicconditions.pdf](http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/20160127_chronicconditions.pdf)).



**New Hampshire:** A reporting effort in the New Hampshire provides comparison reports for cost and utilization for commercial, Medicaid, and Medicare insured individuals, reported statewide and by public health region ([www.nhaccountablecare.org](http://www.nhaccountablecare.org)).



Over half of the APCD states are either accessing or applying for Medicare data through CMS, most through the CMS state data request process (<https://www.resdac.org/cms-data/request/state-agency>). Additionally, about half of the APCD states are working with their Medicaid agencies to include Medicaid data in the data system. The APCD Council website includes a map of states, which details the attributes of each state APCD, including the sources of data collected: <http://www.apcdouncil.org/state/map>. In some cases, there is full integration of the data in the data system. In cases where data are not fully integrated into the same data files in the APCD, these data sources are typically still housed concurrently within the APCD system. This allows the state to analyze data in similar ways.

*3b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?*

As illustrated above, APCD data can be used to calculate a range of population health and quality measures. These data are typically able to be analyzed after sufficient claims lag for adjudication processes, typically about 9 months after the service date. Because state APCDs have historically collected data from the majority of commercially insured lives in a state, there is typically sufficient sample size to allow for sub-state analysis, which is important given the amount of geographic variation in cost and utilization within a state. The APCD Showcase ([www.apcdshowcase.org](http://www.apcdshowcase.org)) inventories state reporting and analysis efforts. We encourage a review of that site, because a full description of the myriad ways the data can be used is beyond the scope of this comment.

Worthy of comment, however, is a challenge that states have traditionally had in accurate and consistent provider identification. While the National Provider Identifier is typically well-populated in most state APCDs, there are limitations with provider identification. One major gap is the lack of a standard mechanism to assign providers to group practices. In addition, provider organizations and healthcare facilities often bill under multiple NPIs, and states often attempt to address those issues by developing a master provider file, which is typically a manual effort at the state level.

For states that have done provider-level reporting (e.g., Colorado), one key aspect to the process is the local engagement of the provider community to review the analysis prior to distribution. This can be a key step in identifying data anomalies and addressing issues.

To date, the linking of APCD data to other data sources has been done in limited ways. There are examples of the linking of APCD data with Cancer Registry data, for example, in Maine and New Hampshire. There is also a great interest and some limited examples of linking APCD data to clinical data in Health Information Exchanges (e.g., in Vermont). Tying APCD data to other data sources remains an area of great interest at the state level, and an area of great promise. Of important note, as CMS moves away from using Social Security Number and to assigned identification numbers specific to CMS, the linkage ability is hindered.

As previously mentioned, the breadth of data collection in an APCD allows for sub-state analysis, and reviewing outcomes from APCDs alongside social determinants of health data in similar geographic areas is of great interest to states. This kind of population health approach will require continued building of infrastructure, and a focus on building often underfunded data systems. The movement of states to associating payment to outcomes is in its early stages. There is an opportunity to continue to build not only the data collection and analysis capacity, but also to build the infrastructure for change that will move to different payment approaches that tie payment more directly to outcomes.

*3c. to what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?*

Each state will have unique perspective, and data release policies, for its own MSIS and T-MSIS experience. The APCD Council leaves the input about this issue to each state.

*3d. to what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?*

There is varying capacity at the state level to perform analysis and build measurement tools to support transformation efforts. Many states (e.g., Utah, New Hampshire, Maine, Minnesota, and Maryland) rely on a mix of in-house and contractor capacity to meet the analytic needs. Massachusetts is the only state that has the operations and analysis “in-house.” In an era of diminishing state budgets, investments in data capacity could result in much more reporting and analysis of health quality, cost, utilization, and outcomes measurement. The state profiles on the APCD Council website provide more detail about the operational approach for each state.

Also worthy of note is that states that have allowed release of data to researchers and others to expand the possibility of the data to be used to support measurement and analysis to support transformation efforts. States have made limited use and public use data files available for release. State data release processes are also listed in the state profiles on the APCD Council website. Examples of research projects that have been submitted to state data release processes can be found in the state summaries of research requests, including in MA (<http://www.chiamass.gov/apcd-application-received-and-commenting>), Maine (<https://mhdo.maine.gov/datarequest.aspx>), and New Hampshire (<https://nhchis.com/DataAndReport/LimitedUseDataRequests>). The data release policies for each state are linked on the profiles on the APCD Council website.

3e. What support can CMS provide to improve states' access to reliable and timely data?

CMS can play an important role in state data improvements. These include:

1. Continued investment in state infrastructure for APCDs. Many states used SIM and other Federal grants to expand data collection, improve data reporting, and/or develop additional infrastructure for data collection. There are many opportunities to do more reporting and analysis with the data, including the linkage examples discussed previously. CMS including those improvements in future grants would allow for important advances at the state level. CMS has been very supportive of states seeking to use Medicaid match funding to support the APCD efforts that are beneficial to Medicaid. Continued support of the use of Medicaid match funding is important.
2. Continued support for state data access. CMS was extremely responsive to state needs for Medicare data, which resulted in the development of the state agency request process. Continuing to identify ways to streamline those requests could be beneficial.
3. Support of state needs for substance use data. States have experienced challenges in acquiring data related to substance use treatment, due to concerns about 42 CFR Part 2. The APCD Council submitted comments to the Substance Abuse and Mental Health Services Administration (SAMHSA) proposed rule modification (<https://www.apcdouncil.org/news/2016/04/apcd-council-submits-comments-sahmsa-regarding-proposed-changes-42-cfr-part-2>.) CMS can work with SAMHSA to solve for this issues around this rule, which is vitally important to getting better data to understand substance use issues.
4. Work with the Department of Labor to find a solution for self-funded data. In March 2016, the Supreme Court ruled in *Gobeille v. Liberty Mutual* that Vermont's mandate that requires submission of data could not be enforced for self-insured employers covered by ERISA. The APCD Council and the National Academy of State Health Policy have submitted comments to a rule from the Department of Labor that outlines a solution that addresses the Supreme Court decision that would allow data to continue to be submitted to state APCDs (<http://nashp.org/next-steps-for-apcds-us-department-of-labor-dol-rulemaking/>). CMS could work with DOL and states in moving that solution forward.
5. Address confusion around submission of Medicare Advantage data to APCDs. In some states, insurers offering Medicare Advantage plans have expressed concerns about submitting those data to state APCDs. While CMS has provided guidance to states indicating that there are no CMS restrictions related to those data, continued clarification on the issue would be helpful.
6. Work with the Office of Personnel Management (OPM) regarding the submission of Federal Employer Health Benefit (FEHB) data. In some states, carriers providing coverage for FEBH plans have expressed confusion about their ability to submit those data to state APCDs. OPM has expressed interest in understanding how it could develop documentation of data procedures at the state level that would allow OPM to provide approval for submission of FEHB plan data to state APCDs. CMS could work with OPM to understand and adopt its state agency approval process.

7. Support state and industry efforts to standardize data collection for APCDs. States and commercial payers have worked extensively to identifying a common approach to data collection in state APCDs. CMS can engage in and support the implementation of those state efforts.

*3f. How can CMS support improve access to and linkage with health outcomes measures data?*

As previously mentioned, investments in state data infrastructure will be important. In addition, CMS has done terrific work in analyzing and reporting CMS data publically. As CMS develops its methods for that analysis, sharing the methods (as granular as the code to perform analysis) such that they can be replicated at the state level for commercial and Medicaid data could be an interesting next area of work. Finding those CMS-state partnerships could be mutually beneficial. In addition, CMS could promote linkage of data by demonstrating successful linkage of Medicare data, and share that science.

*3g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?*

Data quality and integrity checks are inherent in the state APCD operational processes. As mentioned previously, most states rely on contractors to support data collection and processing functions. Data quality checks at the file and field level at the time of submission and for analytic uses are in place in APCD operations. More about these levels of quality checking is described in the APCD Development Manual at: <https://www.apcdcouncil.org/manual>.

*3h. What IT infrastructure is available to states to use data to support transformation efforts?(e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?*

APCDs have been in operation in over a dozen states; collecting, managing, analyzing, and releasing APCD data for over 15 years. States and their contractors have developed significant experience in the data collection and analysis systems in that time, including data extract, transform, and load (ETL) functions; aggregation, analysis, and dissemination functions. Infrastructure at the state level includes deep data storage, data release, and analysis expertise, as well as physical infrastructure of servers, security, and computing.

As APCDs have evolved, however, so too have the data collection efforts related to clinical data, individual device data, and other population data. States are in a prime position to make use of these new and existing data sets, but will need investments to support building new capacities in data collection and dissemination to fully realize the potential use of these data to support transformation efforts. This includes technologies that allow for robust reporting while maintaining security, mechanisms to allow for direct and probabilistic linkage, and systems for reporting to a wide range of audiences.

**Conclusion**

In summary, states have proven to be innovators in the development of APCD data systems and in the effective use of the data from them. There is no shortage of opportunity to continue to build on those efforts. We encourage CMS to continue to work with states to realize this potential, and would be happy to provide additional information.

October 27, 2016

To: Center for Medicare and Medicaid Innovation

From: Norman Thurston, Director, Utah Department of Health, and Office of Health Care

Statistics RE: Response to RFI

The Utah Department of Health, Office of Health Care Statistics (OHCS) would like to provide information on Utah's capacity to provide access to data that may be helpful to the purposes of this initiative. Specifically, we are providing information about the Utah All Payer Claims Database (APCD).

From 2010 to 2015, the APCD has received claims data from most types of third party payers operating in the state, including:

- Public employee plans (state and federal)
- Commercial insurance
- Third party administrators
- Medicaid/CHIP (both fee-for-service and managed care)
- Dental plans
- Pharmacy plans
- Medicare Advantage plans

Conspicuously missing from this list is Medicare Parts A & B. Of all of the third party payers, Medicare has proven to be the most difficult, most restrictive, and most expensive for us to deal with and at present is the most significant single data source that is not contributing to the APCD. CMS certainly could (and should) take steps to ensure that Medicare claims data are submitted to the APCD and made available just like any other third party payer.

Data files are submitted monthly to OHCS and we are contracted to have the data processed twice a year into a cleaned and refined master database. It is conceivable to move to quarterly processing in the future, but at the moment we have not pursued that frequency, largely due to the added cost.

The timeline associated with processing data is roughly as follows (using the end of 2016 as an example):

- Claims adjudicated in each given month are due to OHCS by the end of the following month. (December 2016 adjudications due by January 31, 2017)
- We allow for a 90 day run-out, so the last data included in the processing cycle would be adjudicated in March 2016 and submitted by April 30, 2017.
- Processing of the 2016 data begins on April 1, 2017 and take approximately 120 days to get to the final database.
- On August 1, 2017, our vendor delivers a copy the final database to OHCS



- We then allow up to a month for data suppliers to verify that their data are represented correctly in the database
- At the beginning of September, the final data is available for release and use.

We wish to note that the unprocessed data that our contractor receives is loaded into a staging database and a copy is provided to us each month. We have found that in some cases, the staging data can be used for analysis and reporting, however, since it is pre-processing, caution should be taken.

The final database contains useful features, such as patient-linkage across time and payer and the inclusion of risk scores for patients.

### **What are the APCD data capable of?**

Claims data provide a variety of valuable insights into many areas of healthcare, including permitting the calculation of spending trends and patterns and constructing quality measures by population, sub-population, geography and provider. OHCS is also cooperating with national efforts to create benchmarks across states or regions.

### **Thoughts about Medicare Data**

OHCS has found that it is surprisingly easy to request and receive Medicare Advantage (Part C) data and that it is surprisingly difficult to get access to Medicare Parts A & B data. There are too many hurdles, barriers, burdens, costs, and restrictions that stand in the way of OHCS incorporating those data into the APCD. Why can't CMS simply provide the data just like every other payer (including Medicaid and Medicare Advantage)?

We wish to highlight that these barriers are simply policy decisions made by CMS and not technical in nature. If CMS would authorize the direct release of the data to the APCD, we could incorporate them immediately. The Qualified Entity (QE) program, which was intended to provide a streamlined pathway to data access is not a workable solution because of both the incredible burden required to request the data and the extreme limitations on the actual use of the data.

### **Population Health and Quality Measures**

With few exceptions, both population health and quality measures can be calculated using claims data. In some cases there are limitations when time is of the essence (such as for surveillance purposes) or when the measures require knowledge of clinical information (such as test or lab results). However, in general, claims data are very capable of answering questions about population health and quality.

Claims data in the Utah APCD include identifying information that would allow the data to be matched or linked with data from other sources, such as social services, housing, or other data sources. Of course, such linking requires appropriate access review, approvals, and resources.

**Medicaid Data**

The Utah Medicaid program submits their data to the APCD just like any other payer (except Medicare). Their technical team provides extracts from their data warehouse. We are confident that all plans for future changes and development will not disrupt the process or data flow, and we expect to continue to receive those monthly feeds.

**Staff Resources**

Our staff is heavily experienced in using the data for the purposes described in this request, however, with a small staff we have limited bandwidth. The state's resources are primarily dedicated to support data collection and data management; however, we do have some sustainable resources for analysis, dissemination, and advising others who use the data. We often find ourselves leveraging our experience through partnership with other entities who have an interest in using the data.

**CMS Support**

The single most important thing CMS can do to support this activity in Utah is to remove all restrictions and barriers to getting Medicare data in the APCD, including allowing our partners and clients to use the Medicare data just like any other claims data. In addition, CMS needs to decrease the delay so that Medicare data are available in a more timely fashion.



CFPC, 505 5<sup>th</sup> St., Suite 404  
Des Moines, IA 50309

October 28, 2016

Patrick Conway, MD, MSc, FAAP  
Deputy Administrator, Center for Medicare and Medicaid Innovation  
Chief Medical Officer, Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Dr. Conway:

We are part of the Learning Collaborative on Health Equity and its Young Children's Collaborative Innovation Network (CoIN). We represent different program models which have focused upon primary young child health care as a point of entry to improving life course health trajectories.

We believe models like ours hold great promise in better responding to social as well as bio-medical determinants of child health and providing earlier and more preventive responses to elevate children's healthy development. Much of our success in affecting child health trajectories occurs with children who have not yet been assessed or diagnosed with a special health care need.

We believe our models deserve attention by states as they look at what their Medicaid programs can do to achieve long-term goals of healthier populations and reductions in health morbidities that drive many health care costs.

Since Medicaid and CHIP combine to cover nearly half of the nation's youngest children (birth to five), it is particularly important that states examine their financing of primary care from a value-based Framework that takes a life-course perspective – including reviewing our own program models for their coverage within primary care models. We believe this will foster further innovations within and across our program models and advance financing structures to sustain effective and evidence-based models of primary pediatric care.

One way to accomplish this is to direct a significant share of the attention and financing in future State Innovation Model (SIM) grants to the pediatric population, and particularly to the young child population that has not yet been diagnosed with a special need or chronic condition. We refer you to

Comments provided by Charles Bruner (for the Learning Collaborative itself) and Bernard Dreyer (for the American Academy of Pediatrics) for further discussion.

Sincerely,

National Kitchen Cabinet Members

- Paul Dworkin, MD, Help Me Grow
- Amy Fine, MPH, Project DULCE
- Maxine Hayes, MD
- Kay Johnson, MeD, MPH
- Angela Sauia, MD, PhD

Exemplary Program CoIN Members

- Deborah Allen, ScD, Boston Public Health Commission, MyChild
- Howard Dubowitz, MD, Safe Environment for Every Kid (SEEK)
- Von Jessee, MA, Help Me Grow National Center and HMG South Carolina
- Uma Kotagal, MBBS, MSc, Cincinnati's Children
- Anita Krolozyk, RN, MS, C-PNP, PMHS and Anita Berry, MSN, CNP, APN, and PMHS, Advocate Children's Hospital, Downer's Gove, Illinois, Healthy Steps for Young Children
- Darcy Lowell, MD, ChildFirst
- Liz Tobin Tyler, JD, MA, Medical-Legal Partnership
- Lily Valmidiano, MPH, CHEES; American Academy of Pediatrics, CA Chapter 3, San Diego



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October 28, 2016

Patrick Conway  
Deputy Administrator, Center for Medicare and Medicaid Innovation  
Chief Medical Officer, Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

RE: Request for Information on State Innovation Model Concepts

Dear Dr. Conway:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to submit public comments on the Centers for Medicare and Medicaid Innovation's (CMMI's) Request for Information on State Innovation Model (SIM) Concepts.

We support CMMI's mission to design and test new models of health care delivery and payment that have the potential to reduce costs while maintaining or improving the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). We believe that CMMI offers a critical opportunity to improve the health care system for the tens of millions of people who rely on these programs today.

**Shifting financial accountability to providers should be tested and evaluated, along with other promising models.**

The Centers for Medicare & Medicaid Services (CMS) has launched several initiatives that would shift financial accountability to providers for the patients they serve. This delivery system approach has promise because it could better align financial incentives for providers and fundamentally transform the way that care is delivered. We support the goal of finding new ways to pay for care that reward high-quality, high-value care. In any future SIM concepts, however, we urge CMS to fully test and evaluate such financial accountability models before expanding them nationwide. While shifting financial risk to providers *may* result in substantial improvements in health care quality and lower costs, there is insufficient evidence demonstrating that it *will* achieve these goals in all circumstances without unintended, adverse consequences, particularly in Medicaid and CHIP and among the vulnerable, low-income beneficiaries those programs serve.

The RFI solicits comment on a potential SIM pathway that could align state Medicaid and private payers around one or more existing CMS models, including Medicaid health homes or integration

Models. We strongly support this approach, but it should encompass a broad array of potentially successful models that may not meet the narrow definition of “alternative payment models” under the Medicare Access and CHIP Reauthorization Act (MACRA).<sup>1</sup> Limiting alternative payment models in SIM to the MACRA definition would undermine the opportunity for states to evaluate innovative Medicaid models that do not require providers to accept down-side financial risk.

We thus encourage CMS to consider other delivery system reform opportunities including those that do not shift financial risk to providers. For example, Medicaid’s flexibility has supported many innovative state and local models of care, some of which have been shown to be extremely successful in improving health care quality and reducing costs without providers accepting financial risk. California’s community-run, non-profit managed care plans have developed innovative models of care through robust networks, meaningful care coordination, and offering a broad range of services that address the social determinants of health.<sup>2</sup> Connecticut’s managed fee-for-service model relies on self-insured administrative service organizations (ASOs) to administer services and achieve health care quality; in 2013, Connecticut’s intensive care management program resulted in a 50 percent reduction in inpatient admissions.<sup>3</sup> These are just two successful examples of state-based payment reform that achieved important results without shifting financial risk to providers.

In contrast, the delegated model of care in Southern California demonstrates the potential pitfalls with delegating financial risk within Medicaid. In that model of care, Medicaid managed care plans pay global capitation rates to physician groups and other health plans, which frequently sub-delegate, — that, is capitate payments and further shift financial risk — to other plans and providers. This convoluted network has led to an opaque delivery system where network adequacy, quality of care, and the value of the care being provided are shielded from scrutiny.<sup>4</sup>

That being said, where providers are willing and able to accept financial risk within Medicaid and CHIP, CMS should test shifting financial risk but must ensure that core functions are provided by the contracted entity and require quality measurement and public reporting. And CMS should comprehensively and carefully evaluate this approach before widely encouraging states to replicate it.

### **Vulnerable and underserved communities should be protected.**

<sup>1</sup> CMS could significantly broaden the category of “other payer advanced alternative payment models” under MACRA to align with existing models of care in Medicaid. We strongly support this approach as described in the comments by the National Health Law Program (NHeLP) to the CMS proposed regulation titled Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (MS-5517-P RIN 0938-AS69).

<sup>2</sup> Brianna Ensslin and Deborah Brodsky, “Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot,” Center for Health Care Strategies, March 2016, <http://www.chcs.org/media/HPSM-CCS-Pilot-Profile-032916.pdf>.

<sup>3</sup> Connecticut Department of Social Services, “A Precipice of the Connecticut Medicaid Program,” <http://www.ct.gov/dss/lib/dss/powerpoint/MAPOC101014.pdf>.

<sup>4</sup> Cindy Mann, “The Future of Delivery System Reform in Medi-Cal: Moving Medi-Cal Forward,” Manatt Health, July 2016, <http://www.chcf.org/~media/MEDI%20LI%20BRA%20RY%20Files/PDF/PDF%20S/PDF%20Sacto07132016FutureDeliverySystemMann.pdf>.

Many health care providers are well-equipped to accept financial risk, particularly large hospital systems that have the infrastructure to provide the administrative functions similar to a health plan. However, many Medicaid and CHIP providers, particularly small groups and independent physicians, those serving rural and medically underserved areas, and those whose patient population are predominantly low-income or sick, may face disproportionate challenges accepting down-side financial risk. In fact, CMS has exempted small providers from some requirements including those under MACRA; exempting those providers, however, could also have the unintended consequence of creating or exacerbating health disparities as they may disproportionately serve people of color. Whether CMS excludes these providers or requires them to participate even when they are not well-equipped to accept risk, vulnerable, low-income beneficiaries would be at risk of adverse outcomes. Nevertheless, evaluating a range of models (including those that don't shift risk) that could support the needs of high-need Medicaid beneficiaries and the providers serving them could also benefit the health system as a whole.

Missouri's health home program, which coordinates care for beneficiaries with chronic physical health conditions or a diagnosed serious mental illness, is a good example. This program was developed from the needs of the underserved population, coordinating care across clinical and social services to help individual's access timely care and increase efficiency. The program leverages the skillsets of non-Medicaid providers who have experience supporting individuals experiencing homelessness, resulting in a significant drop in emergency department visits and preventable hospitalizations while savings \$52 in per member per month costs.<sup>5</sup> CMS should consider using SIM to help states like Missouri expand their health home programs and integrate these services into their Medicaid programs.

We are also concerned that moving too quickly to new financial models that shift financial risk could increase the rate of provider consolidation, which is likely to have adverse consequences for beneficiaries. Providers who are poorly equipped to accept financial risk also may already be less inclined to participate in Medicaid; a requirement for bearing risk could exacerbate access issues by further reducing provider participation in Medicaid. These potential problems underscore the importance of evaluating any new payment models before they are expanded or replicated. Robust data collection and reporting will also be essential to ensure transparency and monitor the impact of any new programs on beneficiaries' access to care and health outcomes.

### **Support program alignment and integration.**

We support the goal of SIM to align delivery system transformation within and across programs and systems. This effort is greatly needed in many states where siloed projects have exacerbated the fragmentation of the health system. SIM has a unique opportunity to help support state efforts to integrate these programs into the broader health care system. For example, many states have multiple programs seeking to serve specific subsets of high-need, high-cost beneficiaries in Medicare and Medicaid, each with different eligibility criteria, funding, and quality measurement. If integrated, these programs could likely be administered more efficiently and support higher provider participation. Any new models that CMS considers should take into account the need for greater integration across programs.

Kathy Moses and Brianna Ensslin, "Seizing the Opportunity: Early Medicaid Health Home Lessons," Center for Health Care Strategies, March 2014, [http://www.chcs.org/media/Seizing\\_the\\_Opportunity-Early\\_Medicaid\\_Health\\_Home\\_Lessons.pdf](http://www.chcs.org/media/Seizing_the_Opportunity-Early_Medicaid_Health_Home_Lessons.pdf).

**Prioritize Medicaid innovation.**

In the Request for Information, CMMI requests comment on models of delivery system transformation that are predominately driven by Medicare. While many Medicare models are important and innovative, the Medicaid program provides flexibility for states and communities to develop models of care delivery that meet their unique needs. Many important examples of innovation in the Medicaid program do not necessarily align with Medicare's infrastructure or the needs of Medicare's population. We urge CMMI to more robustly support innovative models in Medicaid and continue to support and test new ways of providing care that meet the needs of the Medicaid population, including those that do not shift financial risk to providers.

For example, there is growing momentum to find ways to better integrate Medicaid and housing supports. In addition to the important tenancy-based services Medicaid can provide, state agencies are working to find ways to support cross-sector collaboration to better care for Medicaid's most vulnerable and most difficult to reach beneficiaries. Louisiana is an important example of this kind of collaboration, where the state Department of Health and Housing Authority have partnered to provide permanent supportive housing to a targeted group of high-need, vulnerable Medicaid beneficiaries. We recommend that future SIM concepts consider testing this kind of innovative multi-sector model, which has enormous potential to improve care and prevent future health system costs.

The SIM program represents an important opportunity for states to align successful delivery and payment models across payers. We support CMMI's efforts to design and test new ways to improve care for millions of consumers across the country. Thank you again for this opportunity to provide comments. Please contact me at [hkatch@cbpp.org](mailto:hkatch@cbpp.org) if you have any questions or if I can be of any further assistance.

Sincerely,

Hannah Katch  
Senior Policy Analyst  
Center on Budget and Policy Priorities





# State of Louisiana

Louisiana Department of Health  
Bureau of Health Services Financing

Dr. Patrick Conway  
Deputy Administrator for Innovation & Quality  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244  
Submitted electronically to [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

## **Louisiana Medicaid Comments in Response to Request for Information on State Innovation Model Concepts**

Dear Dr. Conway:

The Louisiana Department of Health (LDH) appreciates the opportunity to respond to the Center for Medicare and Medicaid Innovation's Request for Information on State Innovation Model Concepts. We are pleased to provide input on a potential future state-based initiative that would support states to implement alternative payment models that focus on the health outcomes of the entire population of a state through alignment of care delivery and payment across payers.

Louisiana ranks last in the nation in overall health, according to United Health Foundations 2015 Annual Report. In an effort improve its ranking, LDH has in recent years implemented key service delivery systems reforms, most notably the implementation of Medicaid managed care, the privatization of the State-owned charity care hospital system, and the expansion of Medicaid coverage to New Adults.

Between 2012 and 2014, the State entered into Cooperative Endeavor Agreements with local private hospital systems for the management and operations of ten State-owned charity hospitals. These public-private partnerships provided for long-deferred capital investments in aging physical plants, physician service expansions, and access to timely care closing the door on a decades old system of health care rationing for the indigent. In areas where the physical plant could not be made to meet contemporary standards, the State-owned facility was shuttered, the services relocated to the private partner's facility; and, with those moves, Louisiana ended a tradition of health care service delivery that separated the haves and have nots with known disparities in timely access to quality care.

In 2012, the State transitioned from an exclusively fee for service model to managed care for the vast majority of its Medicaid population. Nearly 900,000 people Enrolled into enhanced Primary Care Case Management and Managed Care Organization (MCO) models on a statewide basis. Specialized behavioral health services were

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provided separately through Prepaid Inpatient Health Plan model. In 2015, Louisiana Medicaid moved to an exclusively MCO model, integrating physical and behavioral health services. Nearly five years old, the managed care program has yielded significant health care quality improvements and material per member per month cost savings from the state's fee for service baseline.

On July 1, 2016, Louisiana became the 31<sup>st</sup> state to expand Medicaid coverage to the New Adult population. In just four months, LDH has enrolled more than 330,000 residents. With the addition of this eligibility group, LDH is closing the coverage gap for low income Louisianans. And, the Medicaid program is rounding out to reflect the demographics of Louisiana as a whole – disabled and able bodied, young, old and in between. With nearly a third of the state's residents currently enrolled, nearly 1.6 million people, Medicaid is now the single largest health insurer in the state, giving it the single greatest opportunity to improve population health for Louisiana as a whole.

But these reforms have not moved the needle. Today, building on this foundation, additional reform is needed. LDH's goals for future payment and delivery system transformation are: to administer a simplified, accountable and transparent payment system for Medicaid and uninsured residents, to pay for value and promote the Triple Aim, to invest in the transition to population health management, to vest accountability for quality and total cost of care with providers, to support Louisiana's academic teaching mission and infrastructure, and to ensure a financially sustainable Medicaid program.

Toward these goals, LDH this summer engaged national experts to conduct a landscape assessment, which identified as Louisiana's greatest challenge to health care payment reform systems transformation the Medicaid program's exceptional reliance on supplement payments to finance hospital services. In the aggregate, supplemental payments, including Disproportionate Share Hospital (DSH) and Upper Payment Limits (UPL) payments, account for more than 60 percent of total hospital service payments, while "base rate" per diems account for less than 40 percent.

Per diems are based on 1990s cost reports, widely variable by facility, and universally below cost. Per diems have been decreased by more than 25 percent since 2008 in response to chronic State revenue shortfalls. Supplemental payments often financed with Inter-Governmental Transfers as the non-federal funding source have increased to offset the State funds loss. Neither hospital services payment method, per diem or supplemental payment, support value based payment (VBP). To improve population health, provide for financial sustainability in the face of Congressionally-mandated DSH allotment reductions and diminishing UPL cap with the spread of managed care, and ultimately conform with federal regulations that increasingly require a VBP approach (including the managed care rule requiring the phase out of pass through payments in capitation rates), the state must reduce its reliance on supplemental payments.

Informed by the landscape assessment, including nearly two dozen key informant interviews with health plans, health systems, provider advocates and others, the consultants identified a menu of policy options for consideration, including specific care interventions like Health Homes, innovative service delivery models like Accountable Care Organizations, and more modern hospital reimbursement methods like Diagnosis Related Groupings (DRG) and Enhanced Ambulatory Patient Grouping System (EAPG) that serve as building blocks for VBP.

LDH is currently preparing for the next step in this process: active engagement of stakeholders to develop a roadmap to payment reform and systems transformation over the next 3 to 5 years. Louisiana stakeholder input will ensure that the outcome is reflective of Louisiana values, responsive to Louisiana needs, and accessible to Louisiana where from it stands today (Louisiana is not Oregon, Ohio or Arkansas). Our timeline for reform anticipates completion of the roadmap by the end of SFY17 (June 2017), intensive operational planning effort through SFY18 (July 2017-June 2018), and phased in implementation beginning in Calendar Year 2019.

Key components of the operational planning include re-procurement of our Healthy Louisiana managed care program in late 2017 to include VBP requirements and potentially an ACO option. Early inputs to the development of RFP requirements begins with a Request for Information soon to be released on Provider Led Plans as well as opportunities for our incumbent health plans to present to LDH their experience with VBP nationally, their VBP penetration in Louisiana, and what they believe their organization could bring to Louisiana Medicaid as a successful bidder in LDH's re-procurement of its managed care plan. It also includes preparation, submission, and approval of state and federal authorities required to implement the roadmap, including State administrative rulemaking, Medicaid State Plan Amendments and/or waivers, and contracts.

This planning requires significant State capacity building. LDH is actively recruiting individuals with experience in ACO development and VBP provider contracting in the commercial and Medicaid managed care markets to join its internal team leading this transformation work. However, it will be a select few as the state's political culture has little appetite for growth in public sector employment. Since 2008, Louisiana Medicaid has experienced a 25 percent work force reduction while more than doubling its eligibility workload and adding managed care oversight to its fee for service portfolio. And, where internal capacity needed to support innovation already exists – such as a cadre of health economists experienced in fee for service expenditure forecasting, embedded clinical contract staff responsible for HEDIS data validation or project management of MMIS modernization efforts, and special projects staff talented at policy research and program development – it is overextended supporting daily operations and cannot be readily redeployed to more aspirational pursuits.

To take on the magnitude of work required for payment reform and delivery systems transformation, augmentation of LDH staff through contract resources is essential. However, consultants are costly, particularly those with specialized experience in health care systems

transformation. Multiple national consulting firms with SIM grant involvement have solicited LDH with technical assistance offers, but absent the level of grant funding invested in SIM states the cost is prohibitive. As one consultant recently said, “What cost \$30 million to pioneer 3 years ago (e.g., episode-based payments), costs only \$10 million now.” In Louisiana, where since 2008 successive mid-year reductions have emaciated the agency’s administrative operating budget, a consulting contract on that scale is unaffordable no matter the potential for savings. Some may argue this thinking is “penny wise, pound foolish,” but the pennies we have are quite simply consumed by mandatory functions. And although we have proposed risk-based arrangements with those vendors promising the investment would pay for itself, none have as yet accepted our proposition.

Louisiana also faces significant challenges with access to clinical data to advance VBP. State HIE participation is limited, including a majority of hospitals (predominantly small rural hospitals) but a minority of patient volume (concentrated in large hospital systems with their own EHRs). A top priority of the Medicaid agency since the start of Governor Edwards’ term in January 2016 has been an overhaul of the State’s Health Information Technology strategy. It began with the hire of a physician with significant health care quality improvement experience to serve as the Medicaid Medical Director and a Civil Service reorganization to vest in this position responsibility for both evidence-based clinical policy development (covered services management) with clinical quality improvement. LDH invited ONC leadership to participate in a full day onsite review of its HIT program, resulting in recommendations and an ongoing active TA relationship with CMS; commissioned an HIT landscape assessment and with key findings to inform its HIT strategy development; and, filed the position of HIT Coordinator for the first time in nearly two years. In addition, LDH partnered with the Louisiana chapter of the national Healthcare Information and Management Systems Society (HIMSS) to provide a broad based, independent HIT Advisory Committee to further guide its efforts to advance the adoption and meaningful use of Electronic Health Records.

Further evidence of LDH’s support of a multi-payer approach to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program is its engagement of the Medical Director of the state’s largest independent physician practice, an Internal Medicine physician, to align its managed care quality strategy, specifically its clinical quality measure, with that of Blue Cross Blue Shield of Louisiana. This move in early 2016 anticipated the implementation of Medicaid expansion changing the face of the program from child to adult, and sought to align the financial incentives of public and private payers in the Louisiana market by adding adult core quality measures of chronic disease like diabetes and hypertension as well as preventive services like colonoscopies and mammograms.

In closing, LDH was prohibited by the last Governor from applying for any funding under the Affordable Care Act, so missed the opportunity of substantial federal investments to accelerate systems transformation. But, today we stand ready to leverage the gains made by SIM grant states on the foundation of reform that Louisiana concurrently built. In short, if the federal government seeks to further advance VBP

Name

Date

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nationally, then it must make targeted investments to support states, like Louisiana, not on the front end of the diffusion of innovation bell curve.

I look forward to the outcome of this RFI and hope that the result is a third round of SIM grants targeted to those states that the federal government needs to broaden payer and health care provider participation in alternative payment models and accelerate movement toward Advanced Alternative Payment Models under the Quality Payment Program. Again, thank you for the opportunity to comment. I am happy to address any questions you may have.

Sincerely,

Jen Steele

LouisianaMedicaid Director



UnitedHealthcare®

Stephen Cha MD

Submission due: October 28, 2016

Centers for Medicare & Medicaid Services,  
State Innovations Group

**VIA EMAIL:** [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

Dear Dr. Cha:

**RE:** Request for Information on State Innovation Model Concepts

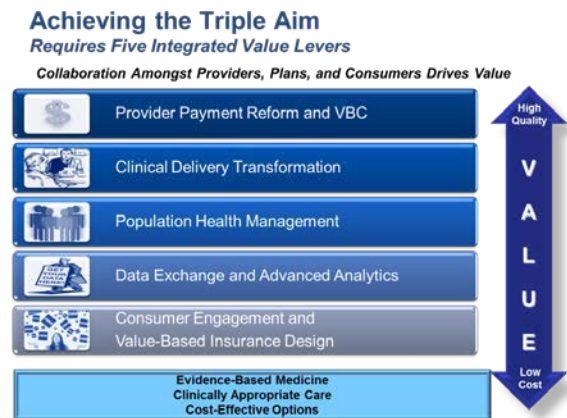
UnitedHealthcare is pleased to respond to the CMS request for input regarding State Innovation Model Concepts. CMS requested feedback on state-based payment and delivery system reform initiatives, implementing financial accountability for health outcomes for an entire state's population, assessing the impact of care interventions across multiple states, and facilitating alignment of state and federal payment and service delivery reform efforts. As a leader in national healthcare reform initiatives, UnitedHealthcare can share our unique experience and feedback in all these areas, from the perspective of an organization that has provided thought leadership in driving these concepts in our states and communities across several decades.

UnitedHealthcare is dedicated to helping people live healthier lives, and making our nation's health care system work better for everyone. We serve more than 45 million people nationally, including 10 million in Medicare and 6 million in Medicaid programs. We are strongly aligned with CMS goals, not only philosophically but also through years of experience empirically testing these concepts in the populations we serve. Our experience has evolved over many years, starting in the west in days when capitation in California was new, then grew through in the era of the Affordable Care Act where we established national PCMH initiatives with multi-payer and multi-product initiated by large customers, such as IBM. We gained experience of what works, and what does not work, first experimenting with different payment models then expanding to clinical transformation initiatives in partnership with our provider communities. We quickly found that payment strategies alone do not transform healthcare delivery and it takes investment in process change and transformation support to change the delivery system. It takes a comprehensive view of the system of care in a community. As SIM has promoted community based care delivery, we too have experimented with testing models that integrated medical, behavioral, social support at the community level. Integration is key to success. Furthermore, we have been at the forefront of working with super utilizer models, working with Dr. Jeffrey

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Brenner in Camden New Jersey, among others, and have since implemented models across the country focused on reaching and engaging our most frail and high cost members.

Our success is a direct result of our investment and efforts in improving population health outcomes, improving patients' experience of care and lowering the total cost of care for our



customers, even before Dr.

Berwick so aptly described this as the Triple Aim challenge. As the nation's leading healthcare payer we manage diverse populations in both public and private programs and we focus on the **following five core value levers needed to drive improvement in our communities**. We have implemented transformation initiatives in ACO and CCO

partnerships across hundreds of communities nationally in Medicaid and Medicare. Our consistent experience is that the following five value strategies must be integrated in order to achieve the Triple Aim. While each lever is necessary, alone they are insufficient to maximize value in healthcare.

#### 1. Payment reform and value based contracting

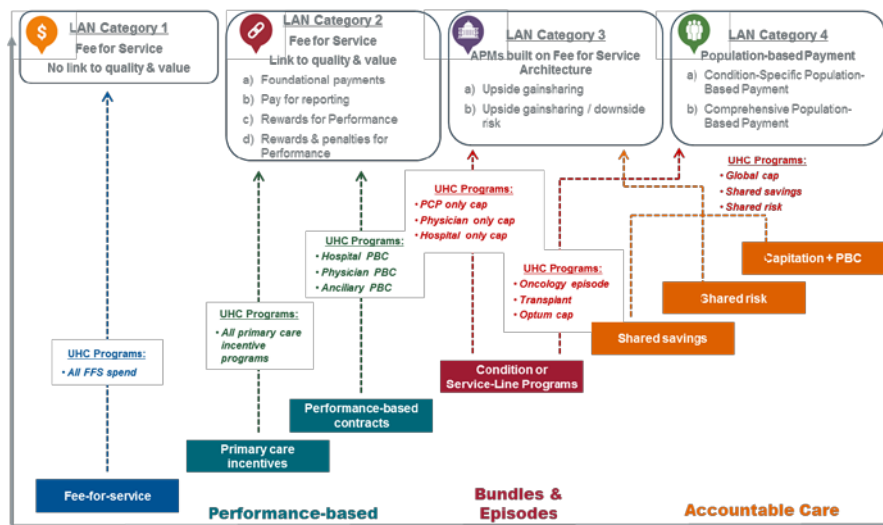
UnitedHealthcare has been committed to payment reform initiatives for many years – beginning with capitation 30 years ago and reform in the California delivery system. Provider Payment Reform and Value-based Compensation today includes multiple payment models we offer providers to support the transition from volume-based payments to value-based payments. Examples include performance-based contracting, episode bundled payments, shared savings or shared risk arrangements, and capitation with value-based payments. In October 2016

McKesson published research noting that payers estimate nearly 60 percent of payments will shift to value-based reimbursement in five years. UnitedHealthcare is far ahead on that count with \$52 billion in spend for our commercial, Medicare and Medicaid lines of business our goal is 85 percent of our payments in value based contracts by 2018 and today we are at 51 percent.



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Our experience implementing these models over many years means we can contribute significantly to lessons learned, and the evolution of Advanced Payment Models. Our VBC teams actively participate in the Health Care Payment Learning & Action Network. We have aligned our VBC models with LANAPMs and are able to assist states with aligning APMs to meet their VBC goals in their SIM initiatives. This graphic highlights the alignment.




## 2. Delivery System Transformation

Our commitment to delivery system transformation has been evolving since 2008 and our first Patient Centered Medical Homes. IBM, a key customer, asked United to measurably improve preventive care and clinical outcomes, piloting a Medical Home model in 2008 and partnering with the delivery system. Our collaboration with this group of clinicians enabled United to identify the core tenets of our program to support health care delivery in the community and later expand it to Medicaid and Medicare. United supported clinics with process transformation consulting to help them become certified by the National Committee on Quality Assurance as a patient centered medical home. This was a successful strategy to improve quality outcomes – we learned from this experience that a medical home model is not in itself sufficient to fulfill the promise of the Triple Aim – lowering the costs of care and improving patient experience of care. We saw that 70 percent of marginal cost improvements come from inpatient and emergency visits – even higher in some vulnerable populations. This foundational work lead

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directly to creating partnerships that became the country's first payer lead Medicaid ACO model known as our Accountable Care Communities program. Our focus went beyond a medical home, with a shared community wide goal to lower high rates of hospitalization at a population level. First year results showed increased primary care visits by 21 percent, while lowering admissions by 30 percent and lowering avoidable emergency visits by 16 percent. These community collaborations have been so successful that we have deployed these support strategies in all segments with positive results:

		
<b>Commercial<sup>1</sup></b>	<b>Medicare</b>	<b>Medicaid<sup>1</sup></b>
<b>11% reduction</b> in hospital admissions per 1,000	<b>26% reduction</b> in inpatient use over the last six years	<b>21% increase</b> in primary care visits
<b>7% reduction</b> in readmits within 30 days	<b>15% higher</b> Star ratings in markets with a majority of members covered under accountable care programs	<b>16% reduction</b> in hospital admissions per 1,000
<b>8% reduction</b> in ER admits per 1,000		<b>14% decrease</b> in readmits within 30 days

<sup>1</sup> Commercial and Medicaid ACO results

Our work is supported through a proven model supported by six essential clinical transformation processes. Payment reform and delivery system transformation are foundational, but not



sufficient to drive the broad based improvement in population health including prevention and wellness to complex care. Key factors in effective population health management include the active integration of medical and behavioral health and whole person care for the individual, including social determinants of health. Our

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Patient Centered Care Model strategy includes clinical transformation support to both Accountable Care Organizations and Care Coordination Organizations who proactively engage and manage the highest risk, super-utilizer, populations and deliver individualized care coordination services. Today, we have more than 750 value based contracts nationally, and our ACO programs reach nearly 800,000 members in Medicaid. We stratify our ACOs into three performance tiers to enable successful ACOs to move up the risk continuum and to remediate performance with those who have been less successful. We launched ACO Forums twice annually to create venues for sharing experience between our leading ACOs nationally, including Medicaid, Medicare and Commercial ACOs. Our private sector initiatives and innovations can be deployed successfully across all populations.

### 3. Population Health Management Programs

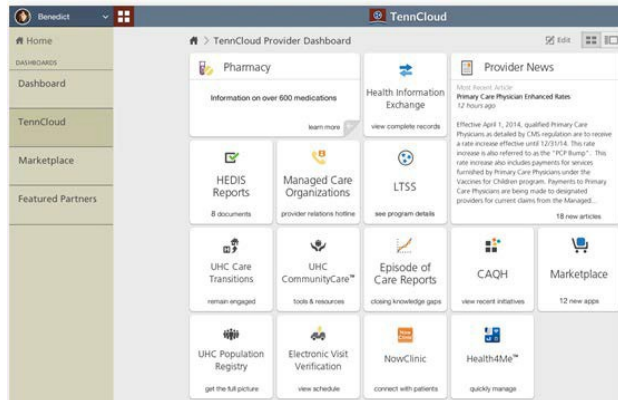
UnitedHealthcare serves members in diverse populations across commercial, Medicare, Medicaid and Military and Veterans segments. We manage programs covering the full range of clinical risk and complexity: children, adults and the elderly with clinical needs ranging from healthy, to those with chronic conditions, to fragile and complex patients of all ages. Patients with behavioral health needs and social support needs (including basic food and shelter) are among the most vulnerable and underserved. Our experience shows that behavioral health and social support needs play a major role in health outcomes, yet these needs have often been unmet, or uncoordinated with basic medical care. We have active initiatives to address these challenges. The integration of medical, behavioral and social support at a community level - **whole person care** - is a key clinical and business imperative for UnitedHealthcare. Our CCO programs have been successful with community based CCO teams to engage persistent super utilizers on track to drive \$58.5 million in savings in 2016 in Medicaid and Medicare populations through lower rates of admissions and readmissions in these populations.

### 4. Data Exchange and Advanced Analytics

We share the same goals as CMS and ONC for the use of information technology in the health care system: to improve the quality of care; develop technologies to deliver innovative solutions; advance interoperability and health information exchange for administrative, clinical, and patient-reported data; and reduce costs and administrative inefficiency. Our core expertise is in population health analytics. We continue to develop and evolve a sophisticated information technology infrastructure that supports Population Health Management principles that have advanced well beyond the era of RHIOs. We have experience implementing state of the art solutions, including third party vendor solutions for Care Transitions management and

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Community Based Care Coordination and supporting providers as these solutions are deployed. An example is at TennCare where the state has implemented TennCloud statewide for multipayer in Tennessee – this virtual cloud based environment provides technology applications in one place with single sign on and facilitates interoperability for multiple



stakeholders. It includes a single common care management platform for all providers. TennCare is leading the way in implementing our solutions state wide, and is a model for others to follow. Delaware and Louisiana have also adopted our cloud based solutions. Optum has a variety of products that enable

communication between technology, processes, and people. These products facilitate health care portability and remove the boundaries that currently impede administrative and clinical information exchange.

UnitedHealthcare has defined core principles to guide development of platforms in a way that supports clinical workflows, investing significantly in connectivity to share relevant, actionable and timely information with providers. This includes real time or daily ADT alerts, peer comparison reports, episode bundle reporting, premium designation reporting, HEDIS gap closures. A critical aspect of technology enablement is to break down the silos of healthcare between health plans and providers in the community and create interoperability.

With respect to measurement, outcomes and advanced analytics, we advocate for radical simplification and standardization of core clinical metrics. Based on our experience working with providers we see significant barriers created by the plethora of measures being requested by national organizations. For example, we identified 22 discrete clinical programs being sponsored by CMS, with 1,555 different measures being promulgated in these programs, and in SIM initiatives alone there are 160 different measures being implemented nationally. Our experience is that, faced with this onslaught of measurement, providers become disengaged in attempts to manage change. They are unprepared to focus on driving change and reducing

Dr. Stephen Cha CMS  
Dr. Sam Ho UnitedHealthcare  
Response to CMS RFI

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variation in care delivery. We ask CMS to consider prioritizing the critical few that are essential to reaching triple aim goals: managing total cost of care, lowering admissions and avoidable emergency room use, and creating effective strategies to engage the most complex populations. We are strongly committed to HEDIS measures such as Medication Reconciliation Post Discharge (MRP) since evidence shows that these are effective in lowering readmissions.

#### **5. Consumer Engagement and Value Based Insurance Design**

UnitedHealthcare has invested heavily in consumer engagement and consumer incentive programs and innovations to support population health and consumers decision making: for example Health4Me, is a mobile application that brings important health information to consumers on the go. It provides access to registered nurses and personal health benefits information, and the ability to locate nearby physicians and hospitals. Innovations such as MyHealthcare Cost Estimator, provider selection tools that help consumers find premium designation providers, and consumer tools to assist medication adherence and healthier lifestyle have been deployed nationally.

With this experience, we aim to be an effective collaborator with CMS and our states as they implement new models to transform the health care system. We currently work with ten testing states to support SIM initiatives: Colorado, Connecticut, Delaware, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee and Washington. Our local and national leaders across our enterprise are engaged with SIM initiatives. Local teams participate in SIM workgroups and our national clinical and network leaders ensure that local objectives are included in value-based contracts for providers and ACOs. Our SIM Steering Committee provides strategic oversight to align internal standards and models with state goals and objectives. We are committed to supporting local teams with the tools and structure they need to achieve results, including coordinating work nationally for quality measures, APM contracts, ACO models, clinical programs, patient empowerment tools and technology support.

Attached, please find our responses to specific topics and priorities. Thank you for your thoughtful consideration of our comments. We welcome the opportunity for further discussion and collaboration.

Sincerely,

Dr. Stephen Cha CMS  
Dr. Sam Ho UnitedHealthcare  
Response to CMS RFI

October 28, 2016

Sam Ho, M.D.  
Executive Vice President, Chief Medical Officer, UnitedHealthcare  
President, United Clinical Services

October 28, 2016

Section I: Multi-payer state-based strategies to transition providers to alternative payment models

Two Pathways on Multi-Payer Models inclusion of Medicare

1. A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation

This pathway could be tailored for a state to launch a multi-payer model, inclusive of Medicare, Medicaid, and private payers, which could be an Advanced Alternative Payment Model. In order for Medicare to participate in a state-led model, a state would submit a proposal to CMS demonstrating how its proposed model meets the set of principles described in the April 10, 2015 guidance for Medicare alignment, and demonstrates that Medicare participation in a State-designed model will be a test of a new or novel model or a test adapted for the unique needs of a state that could be applied on a statewide basis. In order for Medicare to participate in a state-based all payer model, the model would need to be: 1) person-centered, 2) accountable for total cost of care, 3) transformative, 4) broad-based, 5) feasible to implement, and 6) feasible to evaluate.

**UHC RESPONSE PATHWAY 1**

UnitedHealthcare supports models that are based on empirical evidence and are designed to advance the reform efforts of such models. We believe that creating custom models which are not evidence based dilutes efforts and will not achieve objectives. We provide Medicaid Managed Care in 24 markets in the country, and work closely with 10 states on implementing their SIM initiatives. We understand the unique environment in each state and work to align programs with local, regional and national strategies. The following are examples of custom models that we are currently supporting in SIM. This work has not advanced to the point where new evidence is available that would cause us to change direction.

- In collaboration with other MCOs in Michigan, we supported the development of a “custom option” in Michigan that would support advancing the strong footprint of PCMH already present throughout the State as well as using the elements outlined in its SIM plan.
- ☐ In Connecticut we have worked very closely with the State SIM Office and other State Regulators to seek permission to use our proven value-based model of population health management and payment that leads to patient outcomes. We appreciate that the State SIM Office recognizes that payers have advanced alternate payment models already in place with their network providers that fulfill the six components of what CMS wants in a SIM value based payment model.
- ☐ In Colorado we are working very closely with the State SIM Office and the successful Colorado Multi-Payer Collaborative and (a) we signed a Memorandum of Understanding with the State to meet the State SIM goals, and (b) have already created a quality program with SIM providers that meets Phase 1 of the State's behavioral health and physical health integration program.

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## 2. Support states to align with existing Medicare models

The second pathway could be for a state to align Medicaid and private payers around one or more existing CMS models and initiatives (e.g., Medicare Shared Savings Program, Next Generation ACO Model, Comprehensive Primary Care plus (CPC+), Medicaid health homes, Medicaid integrated care models, or episode based payment models), such that a significant number of eligible clinicians in the state or region could become QPs and earn the APM incentive. This pathway is consistent with our guidance in November 2015 that provided further details on ways that states could align with existing CMS programs in order to achieve multi-payer participation inclusive of Medicare.

### UHC RESPONSE PATHWAY 2

UnitedHealthcare does not support integrating models designed for Medicare into other lines of business. There are significant differences in payment structures and value levers in different membership programs. Stringent standardization of models across lines of business and payers may not enable organizations to customize their programs and APMs based on provider readiness and goals. In June 2016, we shared feedback with CMS regarding MACRA, MIPS and APM incentives. Elements of that feedback tie directly to this question with regards to the following:

- ☐ Difficulty aligning quality measures and reporting processes across Medicare, Medicaid and commercial contracts that produce results so that providers and payers can achieve the Triple Aim.
- ☐ Reduce administrative burden to make certain physicians can drive towards quality and successfully transition to a payment system based on value.

We believe there is a high level of interest among states for state-based initiatives which achieve these objectives. States are actively supporting the transition to APMs through their SIM initiatives as well as through Medicaid Managed Care contracts. SIM has afforded states the ability to initiate multi-payer initiatives in a state-wide supported effort; a handful of states are including Medicare programs like CPC+ and episode based grouper models into their SIM initiatives. We are advancing the use of APMs across the country and are working with ten SIM



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testing states to roll-out APMs in alignment with their SIM goals and objectives. Following are examples of this work and a few of the benefits and challenges we are facing.

- ☐ States that require a standard model across all payers may not allow UnitedHealthcare to offer our full range of APMs or programmatic elements of our transformation model. We support the flexibility to implement the model best suited for the provider's readiness and population served to achieve a specific state goal, i.e. 80% of payments tied to VBC, without excessive modification to our contracts or models.
- Providers across the state may not be aware of the state's objectives or goals or are not ready to assume risk for the care provided to their population. States often do not have the resources to broadly educate providers on these programs and do not have the leverage needed to advance systematic change.
- MACRA is making VBC evident to providers, and states could benefit from joint educational materials with CMS and each individual state to discuss the state's goals in achieving its own VBC goals and how they tie into CMS' goals and payers' current VBC programs. Payers can then use that information when contracting with providers.
- ☐ Many successful examples of multi-payer initiatives exist throughout the country. One example is the multi-payer collaborative in Colorado. Continued success of this collaborative has been the result of the clear communication from the state on its goals and objectives, bringing the payers together very early in the process and allowing the payers the ability to build contracts to meet goals without being too prescriptive about the unique thresholds or contract elements.
- Challenges appear when states decide which practices are deemed "contract-able" by payers and the ability for newly formed "accountable entities" to have the processes in place to implement and track advanced APMs.
- ☐ UHC will be participating in CPC+ in CO, NJ, OH, OK, and RI with our commercial business and in OH and TN with our Medicaid business through advanced PCMH programs.
- ☐ Where providers have APMs in any state-wide initiatives, recommendations from CMS regarding Total Cost of Care targets or utilization metrics should not be lower than any existing state selected savings or utilization targets; an example of this is a proposed LAN APM category for CMS models being lower than models currently in place.
- ☐ Accountability is limited when HIPAA and privacy laws do not permit patient information to be shared across all treating providers for the same patient, for example in order to truly integrate behavioral health services with medical services, payers and providers need to be able to more freely share member protected health information related to substance abuse/behavioral health information. In addition, there needs to be an easier and more seamless process in place for patient consent to share information across care team members so true integration can happen and care coordination can be successful.

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- ☐ Implementing multi-payer reforms can be achieved in two years but it should be stressed that obtaining reductions in total cost of care may take longer. Unrealistic expectations of cost savings may deter some providers from continuing with risk sharing agreements.

#### Section I: Question 2

CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.

#### UHC OVERALL RESPONSE TO SECTION I QUESTION 2

Accountability for health outcomes must be meaningful to a specific population whether at a state level or an individual provider level and providers must have access to the right data to make informed decisions about the health of the population they are serving. The program models supported by the states need enough flexibility to allow payers to customize their models to meet the provider's readiness and population. Additionally, providers should have the ability to select a set of pre-defined core measures that best match their population. If SIM States dictate the model and require too many quality measures it creates difficulties for providers and payers to concentrate on areas that require a focused, systematic approach to support full accountability for population health improvements. The technology infrastructure across states is highly variable and we find that payers are ultimately responsible for getting providers the data they need to be successful. Experience in this area includes the following:

- ☐ As states prepare their population health plans, these specific target areas are identified. UnitedHealthcare supports quality measures that are consistent with national standard methodology aligned with HEDIS and STAR measures; performance data must be available to providers through reputable reporting methods, and relevant to the population managed by the provider.
- ☐ Cataloguing SIM measures across ten SIM States, we identified more than 160 unique measures with cross-over between states but a high amount of variability from state to state.
- ☐ Populations included and evaluation methodologies must be transparent and defined in advance.
- ☐ Utilization measures including total cost of care should be key performance measures.
- ☐ Focus on a limited number of metrics and alignment of measure sets and methodology is key. Where providers are asked to address many metrics and goals from different conveners for the same population, the result can often be diluted attention. When different

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measure sets indicate different opportunities for improvement complexity results and attention is lost on the critical few .

- ☐ Barriers regarding resources and tools include multiple state level registries across different programs and systems that are not centralized into, for example, a Health Information Exchange (HIE) capability at the state level.
- ☐ A simplified and consistent patient consent process for HIE would result in fewer patients opting out, and therefore more complete data availability for clinicians. Today, inconsistent and sometimes confusing patient consent processes with HIEs exist widely across the country, which impact the level of detail available to providers and payers required to make an impact at the point of care.

UnitedHealthcare shares the same goals as CMS and ONC for the use of information technology in the health care system and the importance of accessing and sharing data. We provide technology to solve multiple stakeholder interoperability business needs through our many capabilities. We have shared experiences and recommendations with ONC regarding data availability and interoperability. Those recommendations are extremely relevant to SIM initiatives. In our experience, most states rely on the payers to provide data to the providers about total cost of care, and utilization of services. UnitedHealthcare supports connecting to HIEs and is committed to sharing actionable, real-time data with providers to identify utilization patterns, and conduct care transitions. States struggle with a HIE capability across the country, with some states having multiple HIEs but no aggregation of information. Additional findings include:

- ☐ States hire outside vendors to perform program evaluations because of data accessibility issues and subject matter expertise at the state level.
- ☐ We recognize that some HIEs are pursuing NQCA eMeasure certification which could provide assistance with reporting measures for state-wide initiatives.
- ☐ SIM States that have an All Payer Claims Database (APCD) should use that data base when a state needs to use payer administrative claims data in its SIM program. Payers spend time and money to populate a state-mandated APCD, and the purpose of the APCD is to give a state access and use of a payer's claims data, which should then negate/alleviate the need to ask payers for more claims data. We highly encourage SIM States to use their

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APCDs for their SIM programs instead of relying on stakeholders to provide more data for SIM work.

- ☐ A handful of states through their SIM grants, have contracted with HIT vendors to build quality measure and utilization databases. Development of these systems takes a significant amount of time and money.
- ☐ Payers provide individual data and tools to providers to address the needs of those specific members; creating an extra burden for providers to access multiple systems.

## **SECTION II:**

### **Assess the impact of specific care interventions across multiple states**

One key feature of the State Innovation Models Initiative is the flexibility afforded to states to design contextually-specific delivery and payment reforms. This flexibility is necessary given each state's unique market, population, and regulatory environment, and has resulted in a unique set of experiments in each state. For example, nearly every SIM state has implemented a care intervention to improve behavioral health services, but there is great variation across states in their approach: in terms of the types of payment mechanisms used, target populations and provider types, and the overarching models of behavioral health integration (e.g., coordinated care, co-located care, integrated care). While that was by design in SIM Round 1 and 2—these tests were looking at states' ability to use policy and regulatory levers to accelerate healthcare transformation efforts, not at the care interventions implemented as part of that transformation—CMS is also interested in seeking public input on evaluating specific care interventions.

CMS is interested in assessing the impact of specific care interventions across states. States would have the option of seeking these supplemental awards, and in return would agree to implement a standardized care intervention in areas CMS and states agree are high priority for rigorous assessment (e.g., care interventions for pediatric populations, physical and behavioral health integration, substance abuse/opioid use treatment, coordinating care for high-risk, high-need beneficiaries) and participate in a robust evaluation designed by CMS. Unlike SIM Round 1 and 2, states would forego the flexibility of varying the intervention, so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.

1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).
2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?
3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in

this section.

4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.

## UHC RESPONSE SECTION II QUESTIONS

As CMS has indicated, the state-wide models and care interventions currently implemented across the country contain a high amount of variability. Many of the care interventions have only been advanced at a state-wide level for less than two years after having started as pilot programs in select areas or with certain populations. The state Medicaid landscape and programmatic models are highly variable due to legislative drivers. Wide-spread standardization in some cases would require legislative changes. Standardizing care interventions may be more feasible in Medicaid markets with limited payer variation. But in working with states with multiple payers, implementing a standardized care intervention may prove to be difficult for states. Even when care interventions are “standardized”, there is always a bit of variation in the process. We are actively collaborating with states on integration of physical and behavioral health. As one of many payers, we support the framework for integration selected by the state, but have a variety of technology tools and population health analytics that we deploy with our providers to support the model.

- We have seen successes in some areas such as integration of physical and behavioral health in Tennessee’s TennCare program. These services are integrated in a single agency, which is not seen in every Medicaid system. To extend this work, TN has established a common care management platform that is multi-payer. Other states cannot mirror this without legislative support. Variation in network structure in different states creates separate challenges regarding how care interventions can be implemented.
- ☐ From the payer perspective, if a state dramatically changed their care interventions after implementation which altered the performance measures, adjusting existing value-based contracts requires significant lead time as well as the analysis of how the performance will be measured and who is responsible for such measurements.
- ☐ Standardization may be best achieved by starting with what we know drives the greatest impact. This includes the sharing of discharge summaries with primary care physicians, and following standard care transitions processes designed to reduce all-cause readmissions and performing medication reconciliation post discharge. Our clinical models focus on these areas and provide the necessary assistance to providers to establish protocols and processes to carrying out these interventions in a consistent and efficient manner.

UnitedHealthcare has extensive experience in serving vulnerable populations. In our work supporting Medicaid Health Homes, we have found that integrating physical, behavioral and social supports for this population reduces barriers to care and improves outcomes. We support the philosophy of delivering whole-person care, and start with creating a common approach to accountability for the providers and community-based organizations supporting these populations. That accountability starts with the alignment of quality and utilization measures and the use of technology to support information sharing across care team members. The majority of states are not providing a common technology for providers, community organizations or patients to use. We utilize our CommunityCare™ platform in communities to support this effort. Tennessee is one of the only states that we work with that is implementing a state-wide tool to

support care coordination. States likely do not have the resources to support such as tool in the immediate future.

### **Section III: Stream lined Federal/State Interaction**

CMS seeks input on how to improve both coordination among related federal efforts in support of state- based delivery and payment reform efforts (e.g., work groups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

How can CMS/HHS better align in order to support state delivery system reform efforts?

#### **UHC RESPONSE**

##### **SECTION III**

While we currently participate in a number of SIM multi-payer initiatives across the country and strongly support those states that are implementing their SIM projects, it is our corporate mission to advance this work across the country. We have a vast amount of experience in healthcare reform and delivery system transformation and have transformed our clinical transformation and population health models from years of empirical experience. To drive this work forward, we recommend engagement with the payer community and CMS/CMMI State Innovations Group to share payer perspectives on the challenges, the successes and strategies to ensure success as advanced APMs are initiated with more providers. Other opportunities to streamline work are outlined below.

- ☐ We encourage CMS to streamline the number of quality measures and support the Quality Payment Program initiative to allow providers to pick measures most suited to their population.
- We strongly recommend that when a payer, like UnitedHealthcare, has a program or a quality measure or an HIT initiative that meets the goals of a state SIM program, and that is working well for its membership and its networked providers, the state allow the payer to use those programs to count as part of the SIM program work. The less a state mandates its SIM program requirements (through regulations or other mechanisms) and the more states recognize the value in working with current programs that meet and enhance SIM program goals – the more payers and other stakeholders will want to continue to partner with the State to accomplish its SIM goals. Payers and providers are working hard via PCMH programs, CPQ, CPC+, SIM initiatives, and other federal/state value based and sponsored programs to meet the same goals outlined by CMS – and to ask payers and providers to continue to add more to programs that are already working is very hard and not always productive or useful.

**Comments for the Center for Medicare and Medicaid Innovation Request for  
Information on State Innovation Model Concepts  
October 28, 2016**

Thank you for the opportunity to submit comments on the "Center for Medicare and Medicaid Innovation (CMMI) Request for Information on State Innovation Model Concepts." We are specifically responding to the question on page 6: "Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment?"

As do other health plans and accountable care organizations, HealthPartners measures many indicators of patient health with standard metrics that track factors such as patient experience and total cost of care. In order to measure the third component of the Triple Aim, population health, HealthPartners has developed Summary Measures of Health and Well-being<sup>1,2</sup> that align with the recommendations of the IOM Committee on Public Health Strategies<sup>3</sup> and the core metrics identified in the IOM *Vital Signs* report.<sup>4</sup> HealthPartners Summary Measures of Health and Well-being also align with the recommendation of the Population-based Payment Workgroup of the Health Care Payment Learning and Action Network (LAN) to develop "big dot" measures for the area of better health as well as better care.<sup>5</sup>

The HealthPartners Summary Measures of Health and Well-being have three components: current health, sustainability of health, and well-being. The measure of current health is disability-adjusted life years (DALYs) calculated from health care claims and death records. The sustainability of health measure comprises member reporting of six behaviors (tobacco use, fruit and vegetable consumption, physical activity, alcohol use, sleep adequacy, and healthy thinking) plus a clinical preventive services index. While life satisfaction is the top-line measure of well-being, well-being is conceptualized as having seven determinants: emotional functioning, physical functioning, career satisfaction, adequacy of financial resources, social/interpersonal relations, community support, and meaning and purpose.

HealthPartners plans to use the summary measures to identify and address conditions and factors that have the greatest impact on the health and well-being of its members, patients, and community. Other U.S. institutions and organizations have been encouraged to apply the summary measures to their own data to identify and address the conditions that place the greatest burden on the health and well-being of the individuals and populations that they serve. A detailed description of HealthPartners' summary measures of health and well-being was simultaneously published in *Preventing Chronic Disease* and as a National Academy of Medicine Discussion Paper in the third quarter of 2016.

Further development work will be required before the summary measures can be used in payment models, and it is certainly not appropriate to hold providers solely responsible for the "big dot" measures of health and well-being. However, on a Population-based Payment Model Workgroup conference call, participants were invited to envision a future where there might be payment models with joint accountability.

The emergence of geographic accountable care organizations and accountable health communities will require experiments with joint accountability, summary measures, shared goals, appropriate roles, structures, and financing to achieve accountability for health and well-being—not just health care.<sup>6</sup> In combination with the HealthPartners Total Cost of Care Measure, the HealthPartners summary measures of health and well-being provide a measurement and accountability framework for discussion and learning for shared accountability for better health, better care and smarter spending.

Next steps at HealthPartners include but are not limited to:

1. Reporting current health and well-being performance at the level of the health plan
2. Reporting the opportunity for improvement by disease condition and sustainability of health component
3. Identifying opportunities for improvement for sub-populations defined by geography, ethnicity, or other descriptors
4. Tracking changes in health plan performance over time

After adequate experience has been gained with the summary measures, HealthPartners may submit the summary measures to the National Quality Forum for endorsement.

The IOM *Vital Signs Report* asks for measures, “centered on the most important concepts” so that improvement does not remain elusive.<sup>2</sup> We believe that the HealthPartners Summary Measures of Health and Well-being are centered on concepts that matter to patients and are most important for the health and well-being of the American public, and that they are a significant step toward measurement that can be linked to accountability.

Thank you for the opportunity to comment. Please do not hesitate to contact us.

Sincerely,

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Oklahoma comments to the CMMI RFI on State Innovation Model Concepts:

Section I Question 1:

- a) What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?
  - a. Delivery system changes are resource-intensive efforts. Transformation activities have a cost and require adequate funding as a catalyst to development and implementation. Capital resources are required not only by state and local planners, but by the health systems and affiliated providers themselves who are working to analyze impacts and modify systems. SIM test dollars spanning multiple years (in Oklahoma a 6 year development plan is proposed) are indeed vital to the success of continued development and implementation. The continued ability to use Medicaid advanced planning funding for IT infrastructure development is critical to success. Additionally, as states consider additional changes that are likely to result from a new federal administration, now is a critical time for federal investment in states' ability to continue moving in the direction of delivery system reform.
- b) What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholders buy in, IT infrastructure)? How could a future state-based initiative support these factors?
  - a. Critical factors leading to the success of delivery system reform include: formal policy promulgation; a clear governance structure to oversee and evaluate operational and administrative activities; ongoing stakeholder engagement to ensure transformation is feasible and inclusive; investment in supporting infrastructure (e.g. interoperable HIT, practice transformation networks, strong health workforce, etc.); and the ability to leverage existing initiatives (many proposed and supported by CMS) without complex rules or limitations on the ability for crossover among populations and providers.
- c) What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?
  - a. Considering the geographic diversity of Oklahoma, there are significant differences between, for example, urban and rural health systems and providers. A health system's ability to plan for and manage their change to an APM requires support and effort. The health system's knowledge, experience and ability may differ greatly from that of another entity in a neighboring county. The challenge is posed to the state to recognize the level at which the health system is currently functioning, identify what supports the system needs, and deliver the proper amount of support at the right time. Due to limited internal resources and expertise on system transformation, our state we will need assistance through contractors to help create a method to assess health systems at the community level, determine their functional level in terms of ability and readiness

to move into APMs, identify supports the community needs, and deliver the support to health systems, providers, community stakeholders, etc. Additionally, navigating the gauntlet of quality measures presented to providers as the pathway to determine performance as well as base earnings potential requires significant education and support to providers. Again, our state proposes use of contractors to quickly identify and deliver this, envisioning multiple teams working in parallel in multiple areas of the state at the same time. This “all hands on deck” approach will be needed to meet upcoming Medicare and Medicaid deadlines for payment programs.

- d) What resources and tools (e.g. funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g. to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?
  - a. Funding for: planning staff, contractually supported technical assistance (procured specifically by the state as well as TA provided by CMS), execution staff (educators, analysts, etc.), evaluators, actuaries, IT analysts and developers, stakeholder management staff, and regular, meaningful consultation with CMS (Medicaid and Medicare) and CMMI experts. There are at least 13 planning considerations presented in the question above, each needing teams of subject matter experts and their own sets of action plans, activities, and needs. This level of planning typifies the investment required for transformational change to be successful.
- e) If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g. 2-3 years? More than 3 years)?
  - a. The Oklahoma SIM proposal included a 6 year timeline for planning, development and operationalizing the transformation plan. After governance is established, year one would include planning efforts such as initiating the governance team and consulting contracts, state and federal authorization, defining business requirements for implementation, developing practice transformation plans, establishing HIT, readying workforce, finalizing quality measures, and implementing a communication plan. Year two planning activities would include the release of RFP for health system applicants, establishment of the practice transformation center, continuation and implementation of the IT infrastructure; and reporting by payers and providers on quality measures. Year three is envisioned to be the beginning of implementation with award of health system contracts, payments being made, enrollment of members, and incentives paid based upon quality measures. Year four continues implementation with additional payment mechanisms including capitation, withholds, risk incentive pools, and creation of a monthly dashboard to provide transparent data on the performance of each health

System. Years 5 and 6 continue into evaluation and reporting on performance and effects of the changes.

- f) Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?
  - a. As in previous efforts, allowing states to direct their own evaluation efforts provides ownership and flexibility into questions and desired outcomes presented by stakeholders. We support the option for states pursuing their own independent evaluation of their programs. However, acknowledging the need for national comparisons and results, we would also support a federal evaluation effort creating common tests between states. It would be desirable for the details and requirements for federal reporting to be initiated prior to implementation, so that state to federal data reporting can be established, occur routinely throughout the effort, allow for periodic results and 'check points' on performance, and be easily culminated by the federal evaluator at the conclusion of the effort.
- g) What factors should CMS take in to account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?
  - a. Overlap will occur. It is difficult for states, as well as provider and health systems, to manage. The phenomenon of "initiative overload" is real. Multiple efforts put forth by both Medicare and Medicaid, as well as state's choices to pursue activities, while well-intentioned and meaningful, often lead to complex sets of rules, processes, measures, and reporting that must be managed in concert with each other. Streamlining and simplifying policies and communications surrounding multiple efforts, as well as devoting considerable forethought into a coordinated approach from multiple levels (Medicare, Medicaid, commercial payers, etc.) should be first priority for federal efforts moving forward. Assessment of the number of providers in Oklahoma currently participating, or with applications submitted for APM's should be shared with states by federal entities. A federally developed concerted plan to assist those providers currently participating, as well as soliciting information on those that aren't participating, would help inform the discussion surrounding strengths and weaknesses of dual participation in Medicare and state-specific models.

#### Section I Question 2:

- a) Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.
  - a. Oklahoma's SIM efforts have identified and agreed-upon set of quality measures, including many population health indicators. These measures can be found at [https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20\(SHSIP\)%20Final%20Draft.pdf](https://www.ok.gov/health2/documents/Oklahoma%20State%20Health%20System%20Innovation%20Plan%20(SHSIP)%20Final%20Draft.pdf) Pages 132-134. Oklahoma has

found success in payment models most recently with CPCi, PCMH, and readmissions projects. Payments for achievement of metrics (process or outcome) as well as payment for embedded coordination staff have been successful.

- b) Community level payments mechanisms that include required clinical population health metrics as well as community metrics, that are **aligned** across key health conditions affecting the population, should be utilized to reward a community of network providers and the definition of health providers should be broadened to include the public health, healthcare and social service necessary to achieve population health improvement. Relying on community health assessment (now available across most populations due to public health accreditation and requirements on not-for profit hospitals) should be utilized as a key tool by a community network of providers, strong local governance around administration and performance improvement are required, technical assistance on evidence based practice and population health interventions is necessary, provider and community support with quality improvement is necessary and current and relevant local data (clinical and community) are needed.
- c) Oklahoma's SIM model design plan recognizes the critical nature of social determinants on health outcome improvement and proposed the implementation of a social determinants screening for patients upon entry to health system. Individual and community assessment, and hot spotting, will be necessary for both clinical and population health improvement and may require innovative community investment models that would allow clinical health improvement over the long term.
- d) Population (community) health metrics will require a longer term to implement and base outcome payments.

#### Section I Question 3:

- a) To what extent do states, all-payer claims databases, payers, and other key stakeholders have access to reliable and timeline data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?
  - a. Oklahoma has proposed a value-based analytics (VBA) system in the SIM model design plan that marries claims, clinical and population health records to measure system performance. . Two disconnected, private HIE networks are currently providing the infrastructure at the point of care for the state. One of these HIEs includes claims information and both provide analytics at some level. These systems are not interoperable with one another, the state of Oklahoma nor Indian Health Services (and potentially other closed system HIEs). Efforts are underway to join these multiple networks with State of Oklahoma eventually leading to bi-directional flow of data.
  - b. Oklahoma has invested in the foundation of the HIT necessary to develop the VBA but additional funding is required to build the necessary analytics capability to assess and calculate spending benchmarks and trends. Reducing the growth of that spend in healthcare is a key performance benchmark in the Oklahoma Health Improvement Plan 2020.

- c. Our state recognizes the critical need to have data systems collect and report on cost and performance, especially as performance is becoming more so tied to payment. Oklahoma does not have member-specific integrated Medicare and Medicaid data. While the universe of claims has been received, the establishment of a crosswalk between universes has not been created. Full datasets, not only crossover claims, are desired by the state and matching unique members across programs has proven resource intensive but will be eased with the implementation of a new MPI and document repository in November 2016 and additional infrastructure to manage integrated data sets. As Oklahoma's HIE and HIN's are established, at a point in the future additional uses for Medicare data linking to Medicaid sets will be explored.
  - d. The foundation
- b) To what extent do states, APCDs, payers and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g. data sources that include social services, housing, and health care data; appropriate measures)?
  - a. The State of Oklahoma created shared services governance structure in the Health and Human Services cabinet to build a state agency HIE (called Health-e Oklahoma) and document repository capable of creating shared records and registries. The agencies included in the first phase include Medicaid, human services, public health, and mental health and substance abuse, and rehabilitation services. Further, the cabinet has successfully developed a data sharing agreement across eight agencies including the five mentioned above, other child serving agencies, corrections and juvenile justice. Future phases can/will expand to related social services programs. This system will create the connection with other HIEs or providers as well insurance providers and create the foundation for the VBA necessary to tie state payments to outcomes. The system will launch, beginning with the MPI, in late November. A similar model is being developed within one of the private not for profit HIEs in a regional area. Connection with the state will enable this effort. Real time Medicare data will be necessary at some point in the future to evaluate the effectiveness of payment and delivery reforms.
  - b. Work is underway in Oklahoma to establish a common, agreed upon set of quality measures to be incorporated into programs at state agencies, as well as among payers. While some measures are readily available in certified EHR systems, others, due to lack of standards, structured data and required inclusion, are incredibly difficult to measure (e.g. obesity, BMI, tobacco use, etc.). As a result, the state identifies a set of quality measures, acknowledging initially a limited set of measures will have easily available data sources and work is underway with the two HIEs to arrive at solutions for potential population health reporting. Clinical and process healthcare measures have been the priority focus. Social service and other community-support measures have yet to be fully explored.

- c) To what extent do states have the ability to share Medicaid data with CMS, including any backlogged MSIS submissions? Will states be able to transition to the T-MSIS in time to support this work?
  - a. Oklahoma is current on MSIS submissions, and plans are underway to transition to T-MSIS in a timely manner.
- d) To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?
  - a. Oklahoma has relied upon the experience gained through involvement in CPCi and in the future, CPC+ efforts to build internal state-based capacity. Data aggregation and analysis as well as outcomes analysis are the areas with the most state expertise either in state agency staff, HIE vendors, or academic partners. We recognize the need for expertise in especially establishment of spending calculations and payment methodologies, and propose the use of contractors to initially build and operate such systems. At a later date and after experience has been gained, it is envisioned for the state to assume operational responsibility for such systems.
- e) No response
- f) No response
- g) No response
- h) Health-e Oklahoma is a component based system that includes interoperability, MPI, document repository, enterprise service bus, HISP, among other technologies. Once fully implemented the infrastructure will be largely developed. Continued federal funding support for the development, implementation and maintenance of the system and resultant data is required.

## Section II Questions:

- 1) CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g. leverage Medicaid authority to test interventions across its entire Medicaid program).
  - a. Oklahoma has also utilized Medicaid as the largest state purchaser of care to push out policies and programs targeting specific identified improvement areas. The relationship among Medicaid and other state agencies is positive and strong. In Oklahoma, using Medicaid as a platform could be successful due to the efforts already placed into building and maintaining this relationship. In addition, the Governor's goals on health reform acknowledge the state's full purchasing power (Medicaid and state employee insurance) as a mechanism to both influence and ease the transition costs for health providers.
- 2) Would states be willing to standardize care interventions to align with other states participating in a federal, innovation-center led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes,

How much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?

- a. Oklahoma would be very cautious to engage in, yet another, care intervention model that is separate and distinct from existing efforts. From the Oklahoma HHS cabinet perspective, efforts are underway to better coordinate, align, and strengthen the multiple efforts underway in our state. Facing several years of continued budgetary constraints, most if not all agencies are facing difficult decisions about what opportunities can be pursued with shrinking resources. In order for Oklahoma to consider this option it would have to dovetail and include CPC+ and overlap with State SIM goals. Further, significant lead time to plan with the CPC+ initiative would be absolutely imperative.

3) No response

Oklahoma could leverage the relationship between the HHS cabinet agencies (and a future consolidated data set) and potentially use the strong, statewide public health system to focus on social determinants work. A potential intervention could include a pilot and increased funding flexibility to help mitigate barriers to care after a social determinants assessment is administered (perhaps assessing the person AND the community). This effort would require a long term outcome focus and success would need to be measured by achievement of the plans the individual identified as their most pressing need AND health outcome improvement (potential to have a combination of outcomes target including community health hot spotting and improvement). At the individual level outcome metrics may also focus on social determinants pathways that people could graduate through (e.g., becoming eligible for disability, securing quality housing, etc.) Teams including lay health workers and social workers would be needed. Plans submitted should tie community level supporting intervention and improvements with high burden individual social determinants outcomes to measure outcomes. Further, the state partnership with Tribal nations can be explored as an opportunity to implement coordinated programs.

Section III Questions:

- a. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?
  - a. Oklahoma has engaged with federal efforts and officials on projects of value to the state. For example, CPCi, SIM, etc. have provided good connection and conversation with federal officials. Regular communication and unidentified ‘state lead’ for these efforts have been helpful. Federal staff who are knowledgeable of points of contact, not only in their own department, but other departments and divisions, and that staff person’s ability to gather subject matter experts on specific questions of relevance is

Greatly appreciated. On the contrary, Oklahoma's exploration of issues surrounding the federally facilitated marketplace, specifically the ability for the state to collect data from federal sources regarding eligibility, enrollment, coverage status, and exemptions have been very difficult. If marketplaces are to be sustained and improved, interested and involved states have the ability to more rapidly convene stakeholders and develop recommendations (than the federal counterpart). To facilitate this solution-oriented conversation, data are necessary to illustrate and inform the problem. As we are an FFM state, it is our federal counterpart that houses such data. Requests thus far have yet to return a product.

How can CMS/HHS better align in order to support state delivery system reform efforts.

- b. CMS needs to better align the Medicaid/Medicare and CMMI. In some cases the Medicare experience could be very informative to the other centers and states.
- c. CMS/CMMI continues to implement interventions that don't necessarily need to coordinate and that is confusing when multiple interventions are proposed (or being implemented with a state. It is necessary to have scalable, comprehensive and coordinated interventions and anticipating that from the beginning would be helpful.
- d. Common outcome measures need to be identified across all interventions, outcomes should ultimately be health outcomes (not processes), and they should be connected to the community level indicators and narrowed to focus on the highest cost drivers in the healthcare system.
- e. CDC and SAMHSA need to be better integrated and part of the conversation on evidence practices. In all cases the clinical preventive services must be a focus.



October 28, 2016

Director Patrick Conway  
Center for Medicare & Medicaid Innovation  
P.O. Box 8016  
Baltimore, MD 21244-8016

*Submitted electronically to [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)*

**RE: CMS Innovation Request for Information on State Innovation Model Concepts**

Dear Director Conway:

Consumers Union, the policy and mobilization division of Consumer Reports,<sup>1</sup> appreciates the opportunity to respond to the Request for Information on State Innovation Model Concepts. Rising healthcare spending is long-term problem that threatens the quality and stability of our healthcare system, as well as household, state, federal budgets.

Consumers Union applauds the efforts of the Center for Medicare and Medicaid Innovation (CMMI) to test innovative payment and service delivery models in order to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. We believe CMMI's State Innovation Models, if carefully and strategically implemented in states, with a consumer-centric focus, can incentivize improved access and quality of care while also addressing our nation's spiraling healthcare costs. With the launch of the Healthcare Value Hub<sup>2</sup> and closely related activities at Consumers Union, we are similarly committed to bringing better healthcare value to consumers who currently overpay and experience uneven quality.

As the RFI notes, state governments are uniquely positioned to understand the local reasons for poor healthcare value and to tailor solutions and implement infrastructure changes to address these conditions on behalf of state residents. For these reasons, we are particularly appreciative of CMMI's willingness to embrace multi-payer approaches that might benefit *all* state residents -- beyond those that have Medicare, Medicaid or CHIP coverage -- and Advanced Alternative

<sup>1</sup> Founded in 1936, *Consumer Reports* is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using more than 50 labs, its auto test center, and survey research center, the nonprofit organization rates thousands of products and services annually. Consumer Reports has over 7 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace. This division employs a dedicated staff of policy analysts, lobbyists, grassroots organizers, and outreach specialists who work with the organization's more than 1 million online activists to change legislation and the marketplace in favor of the consumer interest.

<sup>2</sup> Please see [Healthcarevaluehub.org](http://Healthcarevaluehub.org) for more information.

Payment Models that have been expanded to include community based providers and organizations.

It is with this context in mind that Consumers Union provides the following set of comments in response to the RFI.

### **Consumers Union's Response To Section I: Multi-Payer State-Based Strategies to Transition Providers to Advanced Alternative Payment Models**

Consumers Union supports future state-based initiatives that help states implement broad scale, multi-payer delivery and payment reforms and have a focus on the health outcomes of an entire state population through an alignment of care delivery and payment. With respect to these multi-payer models, we encourage the following addition to CMMI's six principles for a state to secure Medicare participation in its model: **(7) the formulation and implementation of the approach use s a public and transparent process that facilitates the input of many stake holders, including consumers and consume r advocacy groups.**

In response to Question 1(d) on resources and tools to design and launch robust multi-payer delivery and payment reforms, Consumers Union believes that states require assistance in setting up a robust infrastructure that allows them to measure and evaluate progress towards healthcare value for all residents. In all but a few states, this infrastructure is currently lacking and states are underpowered to address poor healthcare value on behalf of their residents.<sup>3</sup> As described in more detail below, states must set up and maintain an infrastructure that includes collecting and evaluating price and quality data.<sup>4</sup> This will enable states to take action and make evidence-based policy and legislative decisions. **We recommend CMMI issue a round of grant-making and technical assistance to put this state infrastructure in place .**

In response to Question 1(f) on approaches that allow CMS to meaningfully evaluate state models, Consumers Union agrees that meaningful evaluation of each unique state model is critical to ensure that consumers do not pay more than they would have, or suffer lower quality or increased disparities. To encourage meaningful evaluation, CMS should require the proposed models to improve (or at least keep constant) patient access to care, outcomes, and patient experience. In addition, these results must be measured at the aggregate level for state residents to ensure that costs are not shifted to one group as well as at the micro level to ensure that disparities in healthcare are not worsened and hopefully improved.

<sup>3</sup> Consumers Union, *Measuring Healthcare Value at the State Level - A Call to Action*, forthcoming November 2016.

<sup>4</sup> At the micro level, data can reveal the true drivers of healthcare spending, including hot spots for poor quality and the relative success of value interventions. At the macro level, aggregate data on quality and spending ensures even fixes across the board and provides the overall state healthcare spending compared to economic growth and quality improvements.

In response to question 2(a) on what incentives states and commercial payers can use to encourage payment and delivery reforms, as CMS notes in the RFI, there are multiple pathways to achieving this vision of better healthcare value for consumers. To counterbalance the current emphasis on provider *payment* approaches, we encourage **grant-making that also facilitates a rigorous examination of the non-financial incentives to motivate physician behavior**. There is compelling but not yet complete evidence that financial incentives might be too weak to cause change.<sup>5</sup> Instead, financial incentives should be combined and aligned with non-financial incentives (e.g., peer comparisons, reputation, technical support or assistance, and peer leadership) to effectuate change. To reinforce this idea, CMMI should fund a study or consider grant-making to better inform us about the relative importance of non-financial vs. financial incentives.

In response to Question 3(a) on the extent to which states have access to reliable and timely data to calculate spending benchmarks and monitor cost of care trends within the state, Consumers Union strongly disagrees with CMMI's assertion that "data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers)." Access to usable all-payer claims database (APCD) data is non-existent in most states.<sup>6</sup> Even in states that have enacted legislation to authorize an APCD, either the APCD is not fully operational, inadequately funded or data use is severely restricted or unable to be accessed due to high cost.<sup>7</sup> In addition, APCD data is rarely linked to quality, patient experience or outcomes information. Without such data, states cannot learn their total cost of care (including price, use, quality, and treatment variation data); understand spending flows that may identify and eliminate waste; identify high value providers; assess general health status and disease burden of the state's population; or evaluate the effects of state reforms. In short, absent such data states are NOT well positioned to enact the innovations envisioned by CMMI and to understand the intervention's success or failure.<sup>8</sup>

**For these reasons, we believe it is critical that CMS provide grant funding and technical support to implement and improve this data capability.** We encourage technical assistance and state-grantmaking to create the needed data and analysis infrastructure at the state level.

<sup>5</sup> For example, [Peer comparative reports](#) have been found to be four times more effective compared to profit incentives in improving mortality rates by cardiac surgeons performing coronary artery bypass grafts in Pennsylvania. Jonathan T. Kolstad, "Information and Quality When Motivation Is Intrinsic: Evidence from Surgeon Report Cards," *American Economic Review*, Vol. 103, No. 7, December 2013.

<sup>6</sup> We use the term APCD in our comments to be consistent with the RFI while acknowledging a better term might be All-Payer Database to be inclusive of programs like Kaiser which don't have "claims" but nonetheless have needed data on their enrolled populations.

<sup>7</sup> For example, Minnesota only allows the state health department to access their APCD data, a policy that greatly restricts the ways in which the data can be used.

<sup>8</sup> Consumers Union, *Measuring Healthcare Value at the State Level - A Call to Action*, forthcoming November 2016.

Further, we hope this infrastructure will incorporate not only APCDs but integrate non-claims data sources<sup>9</sup> so that states can develop patient safety, quality, and outcome reports using this combined data.<sup>10</sup> Data sources should include the demographic detail needed to assess all forms of healthcare disparities.

CMS must partner with their fellow agency, Department of Labor, to identify a way to include data from self-funded plans in light of the *Gobeille vs. Liberty Mutual* decision that ruled that self-insured health plans were not required to submit medical claims data to a state's APCD.<sup>11</sup> Self-funded plans cover 93 million workers -- more than half of all privately insured people -- and if these data are excluded, APCD data will be far less representative, accurate, and complete.

Supporting state-level data infrastructure is consistent with the goal of many advocates that states embrace accountability for the healthcare value available to their residents. Among other things, the state is well positioned to guide efforts -- outside the clinical setting -- to improve community and population health. **A form of CMMI grant-making that could aid in these efforts is to provide state grants to build new financial accounting mechanisms that assist states to break down the barriers between these current financing silos, allowing states to spend wisely across the spectrum of social and health spending, as well as recognize savings that might not be realized until many years into the future.** Unlike a provider clinic or private payer, the state is well positioned to benefit from savings for a healthy population over a significant timespan. Creative financing approaches and new methods of fiscal accounting goals could assist states recognize and leverage these goals.

## Conclusion

Consumers Union supports CMMI's innovative payment and service delivery models and the move towards a value-based health care system that will provide higher quality, more affordable care for all consumers. It is imperative to get our health care costs under control and this request for information is an important step in that direction. We recognize and commend CMMI's dedication to this mission; we especially appreciate the effort to engage diverse stakeholders in this process.

As we expressed in our comments, we have several important areas of concern where we would like to see changes and careful monitoring. To reiterate, we strongly urge CMMI to fund robust

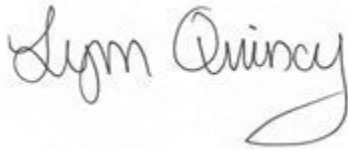
<sup>9</sup> These data sources might include patient registries, vital records, clinical data, and patient reported surveys.

<sup>10</sup> APCD Council Showcase, Combining Electronic Medical Records with Claims Data to Identify Opportunities for Improving Outcomes for Medicaid Patients (September 2013).

<sup>11</sup> *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016).

state infrastructure programs that will allow states to measure and evaluate progress towards healthcare value for all residents, including maintaining APCDs that compile not only all available claims data (including claims data from self-funded plans) but also quality measures and demographic details. Finally, we strongly support grant-making that facilitates a rigorous examination of the non-financial incentives that motivate physician behavior, in addition to financial incentives, and creative financing approaches and new methods of fiscal accounting to help states realize their healthcare value goals overtime.

Sincerely,

A handwritten signature in cursive script that reads "Lynn Quincy". The signature is written in a dark ink and is positioned above the typed name and contact information.

Lynn Quincy,  
Associate Director, Health Policy  
Director, Healthcare Value Hub  
[lquincy@consumer.org](mailto:lquincy@consumer.org)  
202-462-6262

Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-5517-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

October 28, 2016

Dear Mr. Slavitt:

Prevention Institute appreciates the opportunity to submit information to the Center for Medicare and Medicaid Innovation (CMMI) on the State Innovation Model (SIM) concepts. The SIM initiative represented a major step forward in encouraging statewide payment and delivery system reform. The SIM model has supported and expanded meaningful innovation in care management for medically complex patients and encouraged states to think beyond healthcare stakeholders to form collaborations with other sectors like transportation and housing and other partners like community-based organizations to improve population health. It has also led to exploration by CMMI on bridging the gap between clinical care and community services within the current healthcare delivery system to address unmet health-related social needs through the establishment of the Accountable Health Communities model.

The SIM concept has further inspired the development of another model, Accountable Communities for Health, in states like Vermont and California. In Vermont, the [Vermont Health Care Innovation Project](#) (VHCIP) coordinates policy and resources for healthcare reform with the support of a \$45 million dollar SIM grant. As a part of this grant, the state was able to explore the Accountable Community for Health model as a promising vehicle toward reaching the full potential of the Triple Aim of reduced cost, enhanced quality of care, and improved population health, and inform the potential development and application of the model within Vermont's healthcare landscape. Through action being taken by six Work Groups, VHCIP continues to foster collaboration between the public and private sectors to change policies and behaviors to support a new culture of healthcare.

In California, the SIM planning grant and SIM implementation application process, though it was not ultimately funded by CMMI, catalyzed the development of a public-private partnership between philanthropy and inspired the state to create the [California Accountable Communities for Health Initiative](#) (CACHI) to support state-wide healthcare system transformation. CACHI builds on prior efforts and encourages the integration of organizations, programs, funding, and services to address population health within a geographic area – bridging clinical care, community-based resources, and prevention to achieve meaningful and long lasting improvements to well-being of communities. Without the SIM concept, these types of homegrown innovations may not have emerged

CMMI should continue to encourage and incentivize statewide innovation to not only advance delivery and payment reform, but also expand its partnerships to include public health, transportation, housing, education, and other sectors to support the development of community-wide prevention strategies to improve population health across the lifespan. We know that the vast majority of health outcomes are not a result of healthcare services (20%) but from social and economic factors (40%), health behaviors (30%), and the physical environment (10%), therefore bridging clinical efforts with community-wide prevention strategies is necessary along with delivery and payment innovation to create the optimal circumstances to achieve the Triple Aim.<sup>1</sup> Furthermore, as the healthcare system explores effective care coordination, data sharing, and social determinants of health-oriented approaches, future funding opportunities should provide sufficient flexibility in order to foster more innovative and promising payment and delivery reforms. For instance, benefits resulting from innovations that address social determinant of health take longer to demonstrate improved health outcomes, care quality, and reduced costs, so adequate implementation time is essential.

We greatly appreciate the opportunity to provide information on the SIM Concept and are happy to provide additional details related to any of our comments. If you would like more information, you can reach me at [larissa@preventioninstitute.org](mailto:larissa@preventioninstitute.org) or (510) 444-7738.

Sincerely,



Larissa J. Estes, DrPH  
Program Manager, Health System Transformation  
Prevention Institute  
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<sup>1</sup> Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. (2010). *County Health Rankings*  
<http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf>.



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October 28, 2016

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**RE: Request for Information: Input on Potential State-Based Payment and Delivery System Reform Initiatives**

Dear Dr. Conway:

The National Association of Mental Health Program Directors (NASMHPD)—the organization representing the state executives responsible for the \$41 billion public mental health service delivery systems serving 7.3 million people annually in 50 states, 4 territories, and the District of Columbia—appreciates the opportunity to respond to the Request for Information on Potential State-Based Payment and Delivery System Reform Initiatives. NASMHPD is responding to suggest strongly that future alternative payment and delivery system reform initiatives be crafted in a manner different than previous reform initiatives, to better incorporate and integrate behavioral health services and behavioral health process and outcome measures. Such measures should be particularly designed to help detect—in emergency department (ED), inpatient, and crisis stabilization settings—suicidal ideation and self-harming or suicidal behaviors.

While the medical home initiative seems to have had produced some successful integration outcomes in the behavioral health field, largely because it was conceived in statute as a means to incorporate and integrate behavioral health (mental health and substance abuse disorder treatment and prevention) into a holistic health care model, the accountable care organization (ACO) approach has never been designed to encourage participation by behavioral health care providers. If fact, as originally designed, it failed to accommodate behavioral health services or any providers who were not physicians or hospitals.

The original design of the Medicare Shared Savings Program (MSSP), failed to accommodate behavioral health providers, either as lead entities in forming ACOs or as participants in ACO networks. The opportunity for behavioral health providers to become part of the ACO structure grew marginally with adoption of the final version of the regulations governing the MSSP, but participation was still to be restricted by the attribution of patient outcomes to the patients' primary care providers and a continued limitation on which behavioral health providers could participate.

The incorporation and integration of behavioral health into the ACO model began to grow in design and popularity after CMS introduced the concept of the "Integrated Care Model" in a pair of 2012 State Medicaid Director letters. By July 2016, nine state Medicaid programs had active ACO elements or pilots, and a tenth state had submitted a proposal to modify and extend an existing § 1115 (statewide) Medicaid waiver using three separate ACO models. Seven more states were in the process of setting up their



own Medicaid ACO programs. However, even with that growth, one state ACO model that had successfully integrated behavioral health was preparing, after only a couple of years, to eliminate behavioral health integration.

However, the promise that the ACO model could serve as a means of integrating behavioral and medical services in both the Medicare and Medicaid programs has not been achieved. Although researchers have found significant interest in integrating behavioral health providers into the ACO model, challenges have been posed by behavioral health workforce shortages and the slow adoption of costly health information technology by behavioral health providers lacking access to the Medicaid and Medicare meaningful use provider incentives available to other types of providers. Even within ACOs striving toward achieving integration, levels of integration have fallen short.

In addition, even where behavioral health providers do participate in some form of integrated care model, behavioral health measures are seldom used in measuring outcomes or determining shared savings.

Research indicates that the immediate period after discharge from acute care settings is when suicide death is most likely to occur. For ED and inpatient discharges, the risk for suicide attempts and death among all age groups is highest immediately after discharge and over the next 12 months to four years.<sup>1, 2</sup> We also know that as many as 70 percent of suicide attempters of all ages never make it to their first appointment or fail to attend more than a few treatment sessions after discharge from an ED or from inpatient psychiatry.<sup>3</sup> Payment models that focus on preventing re-hospitalizations should include re-hospitalizations for behavioral health conditions and suicidal behavior. Preventing re-hospitalizations by improving care transitions and linkages to adequate outpatient care is critical for patients at very high risk for future suicidal behavior.

NASMHPD makes several recommendations for integrating behavioral health services into ACOs and other Medicaid alternative payment models and delivery system reforms:

- CMS and states should require that ACO leaders and lead entities in other alternative payment models incorporate behavioral health providers in their governing bodies and networks, and include attribution of enrollees to at least some of the participating behavioral health providers.
- CMS and states should ensure that behavioral health quality outcomes and processes are measured and reported in ACO initiatives or any other alternative payment and delivery system reform initiative, and that at least some portion of provider reimbursement is contingent on enrollee improvements on those outcomes. One seemingly obvious behavioral health process measure for incorporation in hospital measures that has been neglected is the reporting by emergency room physicians and other providers of patients admitted to the ED with suicidal ideation and/or evidence of suicidal self-harm. A recent review of two statewide surveillance systems found that 10.7 percent of decedents who died by suicide were seen in a state ED within 6 weeks prior to death. In addition, ED attendees who died by suicide were more likely to have a diagnosis of injury/poisoning diagnosis or mental disorder.<sup>4</sup> As noted in the 2005 study [Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction and Compliance](#):<sup>5</sup>

*Because the hospital emergency department is often associated with traumatic events, it is the ideal environment to perform suicide risk assessments. Further, acutely suicidal individuals may report to the emergency department for crisis intervention and the staff must know how to properly assess the patient's level of lethality and manage their care. ... It is important for emergency department personnel to recognize that risk factors can guide the evaluation of suicide but that good communication among all personnel involved in the care of a suicidal patient is crucial. When patients report sad mood, or loss of interest in pleasurable activities, or when they appear to be depressed,*

<sup>1</sup> Goldacre M, et al, *Lancet*, 1993;342:283–286.

<sup>2</sup> Skeem JL, et al, *Behav Sci Law*, 2006;24(6):731–746

<sup>3</sup> Boyer CA, et al, *Am J Psychiatry*, Oct 2000;157(10):1592-1598.

<sup>4</sup> Cerel, J., et al, *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, Vol 37(1), 2016, 5-12.

<sup>5</sup> Mitchell, A.M. et al, *Top Emerg. Med.*, 2005 Oct; 27(4): 302–312.

*clinicians [can and] should elicit responses to certain questions.*

*In an emergency department setting, suicidal patients [can] be assessed quickly and accurately. The immediate focus of the assessment should be on the safety of the patient and the level of observation necessary to maintain their safety. Their general medical condition [can] also be assessed to determine if they need medical attention in addition to psychiatric assessment and treatment. Some risk factors that may lead the practitioner to believe it is unsafe for a patient to be alone include feelings of hopelessness, a definite suicide plan, a recent suicide attempt, severe depression, psychotic symptoms, a recent discharge from a psychiatric unit, the use of alcohol and/or street drugs, homelessness, or medical illness.*  
...

*Proper assessment and diagnosis of suicide risk and potential can help save the lives of many individuals that are involved in crisis situations. Because patients in crisis often present to the emergency department for treatment, it is an ideal place to perform the initial suicide risk assessment of all crisis patients seeking assistance.*

A measure of the emergency room physician's or crisis stabilization provider's performance of a suicide risk assessment where there is evidence of patient self-harm should be essential to any future alternative payment model and delivery system reform initiatives.

- Behavioral health providers have not been eligible for Medicaid and Medicare meaningful use incentives, and so have not had available the financial resources to adopt health information technology that hospitals and other health providers have had made available. CMS and states should be prepared to offer behavioral health providers incentives—financial and otherwise—for the adoption of health information technology to help facilitate the exchange of patient data between behavioral health providers, and between behavioral health providers and primary care and other medical/surgical providers, and the state Medicaid program.
- In order to facilitate enrollee participation and enrollee self-reporting and provider reporting of outcomes, CMS should ensure that states educate both enrollees and providers on how to best handle behavioral health societal stigma. Education on permissible disclosures under 42 CFR Part 2 restrictions should also be included in any educational and training module provided for participating providers, enrollees, and health information exchanges.
- CMS and states should preempt inevitable behavioral health workforce shortages by considering the inclusion of non-physician behavioral health providers in the network of the ACO or other alternative payment model lead, and the use of tele-behavioral health to supplement in-person treatment.
- CMS should ensure that behavioral health provider reimbursement is adequate to ensure that behavioral health providers are as accessible within the Medicaid ACO or other alternative payment model as they are in the general medical community. If a shared savings approach is to be used, the state may want to consider supplementing that approach through outcomes-based incentive payments sufficient to ensure that providers are not discouraged by low reimbursement from continued participation in the initiative.
- CMS should ensure alternative payment model initiatives integrating and incorporating behavioral health be given time to develop in order to produce sustainable positive patient outcomes and provider revenues through shared savings or incentive payments significant enough for providers to want to participate.
- CMS and states should consider the use of an incentive program to reduce the re-hospitalization rate and improve health outcomes of individuals with behavioral health conditions, including suicidal ideation and self-harming behaviors.

In response to CMS's request for additional information related to implementing financial accountability for health outcomes for an entire state's population, we strongly encourage CMS and state systems to incentivize states to improve the timeliness of reporting state-level mortality data so that state policy makers are able to tie process and outcome measure incentives to reported suicidal events in a timely manner. The delay in the state-level reporting of this data creates a barrier that prevents payers and health systems from being able to accurately

and timely track (by matching health records and state death records) deaths related to suicide—the ultimate poor health outcome for an individual with a behavioral health condition who has been engaged with the health system and/or participated in an alternative payment model.

Thank you for your attention to these suggestions. Please feel free to contact NASMHPD's Director of Policy, Stuart Yael Gordon, at [stuart.gordon@nasmhpd.org](mailto:stuart.gordon@nasmhpd.org) or 703-682-7552, with any questions regarding this response to the RFI.

With respect and appreciation for this opportunity,

A handwritten signature in black ink that reads "Brian M. Hepburn". The signature is written in a cursive, flowing style.

Brian Hepburn, M.D.

Executive Director

National Association of State Mental Health Program Directors (NASMHPD)

# **Principles for Reproductive Health in Delivery System and Payment Reform**

**Guiding Statement:** The health care delivery system transformation underway has the potential to expand access, improve care experience and outcomes, and lower costs for all people. However, unless alternative payment and delivery system models recognize the centrality of reproductive health to women and men's wellbeing, significant opportunities to improve outcomes and lower costs will be lost. For many women of reproductive age, reproductive health providers are their primary or exclusive source of health care. As we develop and implement new models of care and financing we must promote effective integration of essential reproductive and primary health care by providers who serve this population, especially in community-based settings.

The unique opportunities presented by ongoing health system reform are particularly promising for those who face unfair barriers to care, including low-income people and people of color. The integration of comprehensive reproductive and primary health care services should greatly enhance efforts to improve health equity.

Improving women's health care and outcomes should be a priority as new payment and care delivery models are designed, implemented, and evaluated. To achieve these goals, reproductive health care must be fully integrated into the broader spectrum of care. The following principles are intended to guide transformation so that we ultimately create a seamless system that meets the full range of women's health care needs.

## **Transformed Delivery of Care**

### **STAKEHOLDER ENGAGEMENT AND COLLABORATION**

- ☐ **Patients and reproductive health providers must collaborate and engage in all levels of development and implementation of payment and delivery system reform.**
  - Women of reproductive age should be included as partners in payment and delivery system reform initiatives—including in program governance, design/redesign, implementation, and evaluation.
  - Reproductive health providers should be meaningfully engaged in (and supported with sufficient resources for) the development of payment and delivery system reforms that affect essential health care for their patients, including both reproductive and primary care.
- ☐ **New models of care delivery must address the unique needs of women and men of reproductive age.**
  - New models should build in sustainable capacity for reproductive health providers to play lead roles in high-quality interdisciplinary care.
  - New models of care delivery should engage women as partners in their own health and care management, and should be rooted in a patient-centered approach to care.

### **ACCESS TO HIGH-QUALITY, COORDINATED REPRODUCTIVE HEALTH SERVICES**

- ☐ **All care delivery and payment models should be grounded in, and incentivize, evidence-based clinical practice that promotes delivery of safe, effective, appropriate and high quality reproductive health care.**

☐ **Women and men must have ready access to reproductive health care and other preventive services in a system that affords every patient flexibility and autonomy in reproductive planning over their lifespan.**

- Models of payment and care delivery should prioritize reproductive health service delivery and guarantee access to the full range of services related to contraception, abortion, STI screening and treatment, and maternity care.
- Models should not interfere with the ability of patients, in partnership with their provider, to choose the reproductive health services and supplies (such as a method of contraception) that best fit their needs and preferences at various points in their reproductive lives.

☐ **Care coordination efforts should reflect the value of the services, including preventive services and supportive services, that meet the diverse health care and coordination needs of all patients of reproductive age.**

- Care delivery should not be based on a one-size-fits-all model, and patients should be able to choose the provider who is responsible for coordinating their care, so long as that provider is qualified, willing and able to assume the responsibility. Payment models should recognize that for some patients and patient populations, reproductive health providers may be best positioned to engage the patients and ensure that the patient's care is appropriately comprehensive and coordinated.

## **ACCESS TO COMPREHENSIVE NETWORKS OF REPRODUCTIVE HEALTH PROVIDERS**

☐ **Patients should have a robust choice of reproductive health providers, including safety-net family planning centers, specialized abortion providers, STI clinics, public health departments, OB/GYNs, and advanced practice clinicians.**

- Models should recognize roles for safety-net providers of reproductive health services and prioritize community-based settings where women of reproductive age are most likely and effectively able to access care that meets their needs.
- Value-based initiatives and care coordination programs should preserve patients' ability to choose their usual source of care.
- Models should preserve and enhance existing insurance protections related to access to qualified providers, including Medicaid's freedom of choice for family planning and direct access to obstetric and gynecologic care.
- Delivery models should work to overcome the challenges of providing and accessing care in rural and other underserved areas, and payment models should provide incentives for caring for patients in these areas.
- Delivery models and the entities leading them must not discriminate against reproductive health providers (e.g., by excluding them entirely or through reimbursement or administrative rules) and must enable providers to furnish all services within their scope of practice, including abortion and family planning services, so that patients are able to effectively and efficiently access care from their chosen provider.

## **CONSUMER SAFEGUARDS**

☐ **All care delivery and payment models should have robust consumer safeguards.**

- Models should ensure that patients have choice in enrollment and provider selection, transparency that providers may be rewarded for value, access to a fair appeals process, and respect for their individual values and preferences regarding all care, inclusive of reproductive health care.
- Models should protect patients against discrimination on the basis of race, color, national origin, religion, age, sex, sexual orientation, gender identity, marital status, health status or disability.
- Models should ensure that health care services and recommendations are based on a patient's needs and preferences, in line with evidence-based standards and medical guidelines, and not on a provider's or institution's religious or moral beliefs. Delivery models should also guarantee each patient access to all legal, covered health care services without barrier or delay.
- Models of care and payment should protect patient confidentiality and give patients full control over and full access to their health information and records.
- At point of care, models of delivery and payment should demonstrate a commitment to shared care planning and shared decision-making between the patient and her provider. Proactively and explicitly engaging patients in the development of a care plan and in treatment decisions helps to protect against patient coercion and ensure that patients' abilities, preferences, and values are respected.
- Models of care should be culturally competent, trauma-informed, and accessible to patients regardless of language or literacy. Patients should not face additional charges for culturally or linguistically appropriate care.

## **Transformed/Alternative Payment**

- ☐ **Public and private investments must be adequate to build and sustain capacity for reproductive health providers to participate effectively in new care and payment models and to provide the highest quality care for their patients.**
  - Investments should support workforce strategies that ensure capacity to effectively implement new, innovative models of care and meaningfully engage patients in all aspects of care.
  - Priority should be given to enabling reproductive health providers to adopt and maintain state-of-the-science information technology.
  - Measure development in the area of reproductive health should be accelerated, inclusive of patient-generated data such as patient-reported outcomes and patient experience of care.
  - Incentivized quality improvement efforts should focus on eliminating reproductive health inequities and recognize appropriate roles for reproductive health providers in improving health outcomes and care.
- ☐ **Alternative payment models must fairly and accurately value the delivery of comprehensive reproductive health care, including family planning and other preventive services, taking into account its essential role in achieving the triple aim of better care, better outcomes, and lower costs.**

- Payments to reproductive health providers should take into account the full value of the services they offer along the spectrum of care, including the value of preventing unintended pregnancies, STIs, and cancer, and of treating the mother-infant dyad.
- Models should recognize the role and value of reproductive health providers in treating, coordinating care and providing community supports for women of reproductive age who have chronic or complex conditions.
- Financial incentive programs should balance cost-saving interests at the system level with patient preference, quality performance, and health outcomes at individual and population levels. Financial incentive programs should guard against coercion or stinting on care by ensuring patients' abilities, preferences, and values are respected.
- Models must include a sufficient number of quality measures on reproductive health and the preventive services provided in reproductive health settings (e.g., contraceptive use and counseling, and screening for BMI, cancer, STI, depression, tobacco use, and intimate partnerviolence).

### **Signatories**

American Congress of Obstetricians and Gynecologists  
 Guttmacher Institute  
 MergerWatch  
 National Family Planning and Reproductive Health Association  
 National Health Law Program  
 National Partnership for Women and Families  
 National Women's Law Center  
 Planned Parenthood Federation of America  
 (as of October 26, 2016)



October 28, 2016

**VIA ELECTRONIC MAIL**

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, MD 21244

**Re: Request for Information on State Innovation Model Concepts**

Dear Acting Administrator Slavitt:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")<sup>1</sup> appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services ("CMS") as it pertains to the Request for Information on State Innovation Model ("SIM") Concepts. The HCTTF supports the current State Innovation Model initiative as administered by the Center for Medicare and Medicaid Innovation. Indeed, the primary goal of the SIM program – to move 80% of payments to providers from all payers to value-based payment models – aligns closely with the primary objective of the Task Force to move 75% of members' business into value-based care arrangements by 2020. The Task Force commends CMS's commitment to invest in state-based models that seek to accelerate health care transformation.

We believe the State Innovation Model can continue to serve as a key driver for advancing the Triple Aim within the new context provided by MACRA. Our comments primarily focus on the dimensions of transformation where we believe state governments can have the most impact in supporting private sector health care organizations' transition to delivering

<sup>1</sup>The Task Force is a group of private sector stakeholders that are working to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our member organizations aspire to put 75 percent of their business into triple aim focused, value-based arrangements by 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.



person-centered, value-based care, and how CMS can support this activity. We have also responded to the specific model concepts proposed by CMS.

#### **A. General Recommendations for the State Innovation Model Initiative**

We strongly recommend that CMS commit to funding additional State Innovation Model awards. CMS should support all states' efforts to implement statewide healthcare transformation, particularly those states that participated in the most recent SIM planning grant program, with emphasis on the areas below. With support of a Governor's office, CMS should allow for external organizations that could effectively manage the program scope and requirements – such as not-for-profit or academic institutions – to apply on behalf of the State.

##### ***1. Support stakeholder engagement and consumer engagement activities***

As a central component of our work, the Task Force believes that engagement across payers, providers, purchasers, and patients is key to developing sustainable payment models and ensuring robust participation. We recently released a framework<sup>2</sup> that systems can use to ensure consumer priorities remain front and center during all phases of the transformation to a value-based care system, which was endorsed by the Health Care Payment Learning and Action Network's Consumer & Patient Affinity Group. SIM awardees should not only be required to engage consumers as a condition of their award, but CMS should also consider requiring SIM awardees to utilize apportion of any funding to support consumer engagement activities, including educational outreach.

##### ***2. Integrate social services and behavioral health care***

We strongly believe that new models of value-based payment and care delivery should consider the holistic social needs of the patient population, including social determinants of health and behavioral health needs. States are uniquely positioned to support providers that seek to integrate social services into their care management through better coordination of relevant public resources. New workforce programs such as accredited Community Health Workers training programs and new enhanced care management programs that target high-need, high cost patients are promising approaches that should be scaled. CMS should continue to empower local and regional stakeholders to set priorities for improving the health of this population. Additionally, we believe that CMS should support state-led telemedicine efforts for physical and behavioral health care, especially in rural areas, which have the potential to improve the delivery system and increase access to care.

#### **B. Response to Proposed Model Concepts**

##### ***1. Regarding Section I: Multi-payer state-based strategies to transition providers to advanced alternative payment models***

<sup>2</sup> <http://hcttf.org/resources-tools-archive/2016/8/30/addressing-consumer-priorities-in-value-based-care>

The Task Force supports State models that encourage Medicaid, CHIP and private insurance members to adopt payment models that would qualify for MIPS or Advanced Alternative Payment Models. CMS should recognize that States may need a longer performance period to establish a multi-payer delivery model that could qualify as an APM, and should adjust the performance period for future rounds of SIM accordingly.

**a. Encourage payment policy to support transformation**

States are uniquely positioned to advanced value-based payment adoption through state insurance regulation authority for commercial plans – including network adequacy and Qualified Health Plans oversight – and public sector insurance products (*i.e.*, Medicaid, CHIP, and state employee health plans). It will not be possible for Task Force members to meet our goal of 75% value-based payment arrangements by 2020 without commitment from state-administered and regulated programs. States should be encouraged to utilize the full breadth of available policy levers to drive adoption of value-based payment within the public and commercial payer market, in line with the Secretary’s delivery system goals for Medicare. CMS should consider establishing more formal partnerships between SIM participants and national organizations such as the Task Force that can convene multi-payer stakeholders to drive national payer adoption of value-based payment models.

**b. Consider overlap and alignment of Medicare and state-led innovation efforts**

The new incentives for providers to adopt Medicare alternative payment models may stymie private sector and state-based efforts if the Medicare models being implemented by CMS do not explicitly create an opportunity for alignment with state-based models. We are particularly concerned that Medicare models that don’t allow for this opportunity might undermine innovative work being done in States to include consumer voices in the quality metric development process and to promote models that focus on addressing the social determinants of health. **CMS should explicitly allow for flexibility in Medicare models to adapt and align with state-initiated models of a similar design that have already gained provider and payer commitment to participate.**

We believe that CMS can support this effort by publishing the minimum acceptable parameters for Medicare participation in multi-payer state innovation models, including specifying core quality measures sets and minimum levels of risk. We caution against CMS prioritizing alignment over innovative state initiatives that are aimed at meeting the specific health needs of communities. Aligning payment models should be a strategy that help improves health care for consumers, and not an end in itself.

**c. Implement financial accountability for health outcomes for an entire population**

The Task Force supports the design and implementation of models that encourage greater provider accountability for cost and quality outcomes, and would support additional “all-payer”

Models such as those being implemented by Maryland and Vermont. However, **CMS should also allow flexibility to test more mature value-based payment arrangements (such as hospital global budgets) at a regional level or population-specific level, rather than just statewide.** Market readiness for such an arrangement differs by region and statewide market readiness should not act to limit willing participants from entering all-payer arrangements.

**d. Promote transparent evaluation and data sharing**

In principle, we support the goal of making population-level data available and transparent among health care stakeholders. For future rounds of SIM, **CMS should establish core progress and outcomes measure sets that promote alignment across payers and allow for cross-state comparison at the outset of the program.** The Innovation Center also could use the initial round of SIM projects to establish benchmarks and focus data collection and reporting for future SIM projects. CMS can help to ensure meaningful evaluation by developing mechanisms for public reporting of quality and performance measurement data and outcomes, and support tools that States can use to gauge progress. The CMS should also continue to simplify the process for States to access to Medicare claims data, as well as other non-claims based data sets such as OASIS and MDS data.

***2. Regarding Section II: Assessing the impact of specific care interventions across multiple States***

The Task Force supports the concept of multiple States partnering to drive innovation in the delivery system. Patients utilize care across State lines, payers can offer products in multiple States, and providers can operate facilities in multiple States. Therefore, States should be able to partner to implement aligned delivery system reform models irrespective of State borders. Many elements of the transformation infrastructure – including health information exchanges and all-payer claims databases – represent large investments that do not need to be implemented discretely in each State. Further, the early SIM awardees should be incentivized to partner and share resources (such as through a joint award) with other States that have not yet implemented statewide innovation models, to help replicate successful models in additional States.

***3. Regarding Section III: Streamlined Federal/State interaction***

The truncated timeline of the competitive grant application process in the initial rounds of SIM prevented States and CMS from engaging in negotiations for waivers prior to award that would have allowed for more innovative reimbursement structures. In absence of new waivers from CMS and the explicit commitment from participating providers and payers to participate, there is no mechanism in place to ensure achievement of this model's objectives. For this reason, **CMS should comprehensively review SIM applications in conjunction and simultaneously with relevant requests for Medicaid, Medicare, and Section 1332 waivers prior to award.** CMS should also consider funding mechanisms other than a competitive grant or cooperative agreement that would allow for a productive, collaborative negotiation process.

In summary, we support continued investment in the State Innovation Model as a vehicle for accelerating health care transformation to improve patient care while engaging broad stakeholders to align public and private sector efforts. Please contact HCTTF Director of Payment Reform Models, Clare Wrobel, at [clare.wrobel@leavittpartners.com](mailto:clare.wrobel@leavittpartners.com) or (202) 774-1565 with any questions about this communication.

Sincerely,

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**Judy Rich**

President and Chief Executive Officer  
Tucson Medical Center Healthcare

**Dorothy Teeter**

Director  
Washington State Health Care Authority



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October 28, 2016

Centers for Medicare & Medicaid Services Department of Health and Human Services Hubert H. Humphrey Building, Room 445-G 200 Independence Avenue SW Washington, D.C. 20201

**Re: Response to Requestor Information on State Innovation Model (SIM) Concepts**

Dear Administrator Slavitt:

The Maine Health Management Coalition (MHMC) appreciates the opportunity to respond to the above-referenced Request for Information, and CMS' ongoing efforts to align payers in order to advance value-based payment models.

MHMC is a non-profit organization whose over 70 members include public and private purchasers, hospitals, health plans, and doctors working together to improve the value of healthcare services in Maine. As a multi-stakeholder convener, the Coalition has a unique capacity to organize the purchaser and provider of care in efforts to advance payment reforms, catalyze delivery system transformation, and promote and inform consumer engagement. In responding to the Request for Information, we have drawn on our past work promoting multi-payer payment reform in Maine (including through SIM) to identify what we believe are key elements of any successful efforts to drive value-based payment reforms—most notably, a coordinated and aligned commercial approach.

We look forward to working with CMS on this and other innovations that improve the value of healthcare and the health of our population.

Please let me know ([MDeLorenzo@mehmc.org](mailto:MDeLorenzo@mehmc.org)) if I can be of additional assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike DeLorenzo".

Michael DeLorenzo  
Interim CEO

## **Maine Health Management Coalition**

### **Response to CMS Request for Information**

**1a. what challenges do states face in achieving allayer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?**

CMS' decision to shift Medicare to more value-based payments is having a profound impact on health care delivery. Commercial payers insure over 50 percent of the population, both nationally and in Maine. Like the Medicare program, commercial purchasers have the collective market power to drive the healthcare system towards value-based payment models and accelerate delivery system transformation.

Yet to date, that potential has not been realized. Individually, commercial purchasers support and encourage value-based payment, such as partnering with specific providers on bundled payment arrangements or encouraging employees to choose high-value care. But they have not worked together to clearly articulate a shared approach to shifting the commercial market to value-based payments. Collectively they represent the largest payer of healthcare services—with the potential capacity to drive change—but as individual payers their reach and influence is diffused.

In order to leverage the collective influence of the commercial sector, a concerted effort must be undertaken to organize commercial purchasers around CMS' pay-for-value proposition, support alignment of their payment structures with CMS models, and communicate a consistent approach to providers regarding how the commercial market intends to pay for value, not volume, in health care.

Developing consistent commercial payment strategies has not happened on its own, and will require proactive efforts by an organization with the capacity to convene a region's large employers and support their efforts to develop and advance cohesive commercial strategies to drive payment reform. In Maine, the Maine Health Management Coalition has long-standing relationships with many of the state's largest employers and has collaborated with them on quality, cost, payment reform, value-based insurance design, and many other issues related to value-based payment models. Collectively, Coalition members insure over 180,000 lives in Maine. The Coalition will draw upon those relationships, expertise, and portfolio of work to bring together the state's commercial purchasers and galvanize an effort to align the state's commercial sector with CMS' pay-for-value proposition.

Broad-based alignment among commercial purchasers around alternative payment models also will motivate commercial payers to participate. As Maine's response to the CPC+ initiative showed, payers will not necessarily opt to participate in alternative payment initiatives on their own without direction from their purchaser clients. Clear and consistent signals from commercial clients collectively will create strong incentives for commercial payers to support the new payment models that their customers are demanding.

An aligned commercial approach could result in risk-based contract templates that would encourage adoption of common contract elements; consistent clinical episode definitions for bundled payments;



Common performance measures around cost and quality; core value-based insurance design features; and coherent and targeted utilization of data infrastructure.

**1b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?**

Successfully advancing a value-based payment model requires **alignment across commercial and public payers** so that providers have sufficient incentives and support to transform care delivery. As CMS noted when launching the Health Care Payment Learning and Action Network to promote multi-payer value-based payment efforts, “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 the largest purchasers of healthcare services, commercial purchasers are essential to any successful effort to reform healthcare payment.

There are two key components to achieving broad payer alignment that engages commercial purchasers and leverages their market power to advance change. First, commercial purchasers must be organized around the same value proposition that CMS has created for Medicare. However, developing a clear and cohesive set of commercial strategies to advance value-based payment models across the commercial market will require a proactive effort by a trusted convener—otherwise commercial purchaser strategies will remain diluted.

Second, commercial purchasers must be equal partners, from the outset, in development of any multi-payer value-based payment initiative. The project’s governance structure must reflect that equal partnership, with commercial representation on committees consistent with the significant portion of healthcare services paid for by commercial purchasers. The governance process also should be supported by a trusted, neutral (across payers) convener.

**Robust all-payer data** also is essential to multi-payer reform efforts—both to support improvement and to ensure accountability. Specifically, claims data are needed to measure the cost impact of alternative payment models across payers and against spending targets. With cost shifting a long-standing feature of the healthcare system, it is critical that the total cost of care be measured across all payers—Medicare, Medicaid, and commercial—to ensure that lower costs for one payer (such as Medicare) are not simply the result of shifting costs to another payer.

Claims-based analytics are also critical tools to help providers understand cost, utilization, and quality trends for their attributed populations compared to state benchmarks, and to identify variation and actionable opportunities for improvement. Commercial and public payers will also need this information to evaluate and compare performance in alternative payment arrangements and to undertake data-focused improvements that identify and support providers around priority measures, such as diabetes. MHMC is currently using these data to adjudicate both commercial ACO contracts and Maine Care accountability communities contracts.

An analytically functional cross-payer claims data warehouse provides the data infrastructure necessary for this work. A Medicare Qualified Entity (QE) such as MHMC will ensure that robust Medicare data is part of the warehouse. Not only must a cost of care methodology be analytically sound, it also must be understood and accepted by stakeholders. For example, with support from the SIM grant, MHMC has

Developed a total cost of care (TCOC) methodology that has been vetted through a multi-stakeholder process. MHMC was also one of the first organizations nationwide to undertake total cost of care, including both public reporting of TCOC as well as actionable, practice-level TCOC data for providers. MHMC also was an early leader in helping other regional health improvement collaboratives advance TCOC initiatives to drive national health improvement.

**A common, all-payer quality measure set** also is key to any multi-stakeholder initiative to transform care. To that end, the Coalition is planning to create its own qualified clinical data registry (QCDR) to advance a common measure set in Maine. This physician-led process will strengthen alignment between CMS and commercial payers through the creation of locally developed, advanced outcomes-based measures that can be used by both CMS (through MACRA MIPS) and commercial payers.

Such a measurement system requires a comprehensive and up-to-date provider database that allows for the integration and attribution of different performance measures to a particular provider, practice, practice group, or system. MHMC curates a high-quality provider database that is a vital reference tool for many stakeholders throughout the state.

While strong alignment with Medicare payment models is critical, program design must allow individual payers **flexibility** to incentivize their specific priorities and also give providers the ability to choose from a range of value-based payment methods (i.e., tiers) that are tailored to match different levels of provider readiness. For example, a state initiative might use a QCDR-led process to identify a common set of metrics, but give individual payers flexibility to determine the relative weight and value assigned to each measure for their specific populations. Adherence to the HCPLAN Alternative Payment Model (APM) framework provides adequate guidance to achieve the balance between consistency and flexibility.

**1d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?**

The response to Question 1b above outlines several essential components of successful multi-payer delivery system reform initiatives. Many of those components require dedicated resources.

- ☐ as noted above, alignment across commercial and public payers will be key to efforts to transform care delivery. In order to leverage their considerable market power to advance value-based payments, commercial payers must be proactively organized. Efforts to align across commercial and public payers must utilize a balanced governance structure facilitated by a trusted neutral convener, with commercial purchaser's full partners at the table. Resources would be needed to educate and engage payers in the reform effort, and to facilitate and support multi-stakeholder meetings that solicit all-payer input on key components of the model, including those discussed above.

- Resources must also be available to support access and analytics around all-payer data. Such data are essential to measuring the cost impact of alternative models over time and across payers; allowing payers to evaluate performance on risk-based contracts; and helping providers to understand cost and utilization patterns compared to state benchmarks and identify opportunities for improvement. Through the SIM grant, MHMC has already developed substantial infrastructure and expertise that can be leveraged moving forward—including designation as a Medicare Qualified Entity. However, resources would be needed to access, process, and analyze claims data on an ongoing basis. Specifically, in order to generate analytically functional claims data warehouses that support the analyses described above, resources must be available to perform data validation, mitigate data limitations where possible, and apply value-added analytics—such as risk adjustment and episode groups.
- ☐ a comprehensive and up-to-date provider database is essential to any efforts to integrate and attribute performance measures to a particular provider, practice, practice group, or system. Resources are needed for ongoing updates and maintenance to keep the database current.
- ☐ Technical assistance will be critical in helping providers (particularly smaller group practices) understand risk-adjusted cost, utilization, and quality data so that they can identify opportunities for improvement (particularly vis a vis metrics included in a common measure set or a particular contract), and undertake strategies to improve performance. Resources would be needed to support such data and practice transformation training.
- ☐ Following the Supreme Court decision on *Gobeille*, it is unclear whether comprehensive commercial data will be available through state all-payer claims databases. Policy or regulatory changes at the federal level that institute data reporting requirements on ERISA-covered plans could assist in this regard.

**1f. since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?**

While payment models will reflect the unique priorities and circumstances of each state, those models still must be consistent and aligned with the value-based models that CMS is implementing for Medicare. To that end, it is expected that CMS will identify a core set of key cost and performance metrics which can be used as the basis for comparative evaluations among states. Those metrics must include detailed price and quality performance information from systems participating in alternative payment models so that they can be compared to commercial ACO performance.

**1g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?**

State or regional efforts should seek to align all state payers around payment methods that are consistent with CMS' value-based payment models for Medicare. However, each local model also should offer unique and potentially value-added elements that would complement, inform, and potentially enhance existing CMS payment models.

For instance, Maine has an opportunity to not only include commercial purchasers in multi-payer alignment efforts, but also to organize their participation so that they are promoting a unified,

Commercial approach to value-based payment. For example, commercial purchasers could agree to use consistent risk-based contract templates that would encourage adoption of common contract elements, or utilize consistent clinical episode definitions for bundled payments (such as the HCPLAN approach).

Rural states like Maine also could pilot alternative payment models that are tailored to address the specific circumstances and concerns of smaller providers—a group currently exempt from many MACRA requirements—and support rural practices with risk-adjusted cost and utilization data, measurement analyses, and technical assistance. CMS could use those results to more fully and equitably integrate smaller providers into Medicare payment models such as MACRA. CMS should also look to states to pilot innovative ways to coordinate the choices that MACRA affords providers around quality measures, such as a statewide, multi-stakeholder QCDR to develop a meaningful, outcomes-based common set of metrics that can be used for MACRA and by commercial payers.

**2a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.**

Both purchasers and providers are interested in developing more outcomes-based measures that can meaningfully assess health outcomes for a population. A multi-stakeholder QCDR, for example, could advance development of an outcomes-based common set of metrics that can be used for MACRA and by commercial payers to assess performance on population health within risk-based contracts. In addition, risk-adjusted total cost of care methodologies that attribute all of a patient's costs to the patient's primary care practice (such as Health Partners) encourage practices to keep patients healthy to avoid potentially costly care out of the primary care setting.

In Maine, a common measure set adopted through a multi-stakeholder SIM-supported process has achieved broad adoption, with systems and health plans reporting that between 66–72% of 2015 ACO performance measures were from the core set. The measure set includes outcomes-based metrics around diabetes, hypertension, and readmissions measures.

**3b. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and healthcare data; appropriate measures)?**

A major focus of Maine's SIM grant was development of robust data resources to help stakeholders evaluate and improve performance. One key data source available to payers and providers is claims-based data. With SIM support, MHMC was able to generate cross-payer, analytically functional claims data warehouses that can produce a wide range of analytics, including all payer (commercial, MaineCare, and Medicare) risk-adjusted practice-level reports for providers that compare practice cost, utilization, and quality to statewide benchmarks, allowing practices to compare results across all payers (and over time), identify cost drivers and areas of variation, and target potential areas for improvement.

Payers and purchasers use claims data to compare provider performance against state benchmarks and to measure performance on cost and quality metrics within risk-based contracts.

Practice reports and other claims-based analyses give providers detailed risk-adjusted information on trends across their patient panel, and providers report that they find such analytics extremely valuable. Beyond practice reports, claims data can be used to develop a wide range of analyses that can assist providers, including understanding referral patterns (out-of-network and specialty), episodic (bundled) care variations, and key performance indicators—evidence based as well as low value care indicators.

And as mentioned earlier, the Coalition is planning to create its own QCDR that will allow us to pull together clinical and claims data in a common set of metrics that can be used for both Medicare (MACRA MIPS) and commercial payers.

**3c. to what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?**

MHMC has used Medicaid claims data to develop extensive ACO and practice level analyses outlining risk-adjusted variations in quality of care, cost, and utilization. Working with the state Medicaid program, MHMC has created reports for all Maine primary care practices detailing performance on their attributed Medicaid population over time, benchmarked against peer and statewide averages. MHMC also uses Medicaid claims data to assess performance on cost and quality metrics by Medicaid Accountable Communities. If they choose to do so, the state Medicaid program would have the ability to share these claims-based analytics with CMS.

**3h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?**

In Maine, cost and quality data have long supported system improvement. SIM resources expanded and enhanced those efforts, with MHMC developing the infrastructure and expertise within an analytically functional claims data warehouses to (1) create claims-based, risk-adjusted practice reports that give providers a rich set of data regarding their performance against state benchmarks on cost, utilization, and quality measures across all payers (Medicaid, Medicare, and commercial), and (2) measure cost and quality performance of accountable care arrangements for both Medicaid and commercial payers. Ensuring data quality is a key aspect of the infrastructure MHMC has developed around the warehouse. Data quality checks and validation activities include: participating in state's APCD user group in order to understand limitations identified through the QA process; working with data vendor to better understand and surface quality issues through claims processing; reviewing and analyzing potential impact of data issues and anomalies; reviewing reports for consistency and investigating any variation; and delaying release of data/reporting if further data analyses is warranted.

Additional resources will be needed to support continued access to and analysis of all-payer claims data, but the infrastructure and expertise already in place in Maine represent a strong foundation that can be leveraged moving forward.

To: Centers for Medicare & Medicaid Services (CMS), HHS  
Center for Medicare and Medicaid Innovation

From: Marie Zimmerman, Medicaid Director  
Minnesota Department of Human Services

Re: Request for Information on State Innovation Model Concepts

Date: October 28, 2016

Minnesota appreciates the opportunity to respond to the Center for Medicare and Medicaid Services' (CMS) Request for Information on State Innovation Model Concepts, and is supportive of CMMI's goals of continuing to support state care delivery and payment reform efforts in ways that build on state infrastructure and priorities. With our own Requests for Information and state-wide surveys, Minnesota has actively engaged stakeholder input in many areas such as the advancement of e-health use and exchange, value based purchasing models, and ACO activity across the state. Prior to responding to this RFI, the Minnesota Departments of Health and Human Services also solicited input from our external SIM Task Force members and used their answers as a foundation for this response. Minnesota is pleased to submit the following summary, along with the specific responses, for your review and use.

Minnesota's SIM project is comprised of five interconnected drivers, which when advanced together, support coordinated, patient-centered care; expansion of value based payment models; and system-wide collaborative approaches for clinical & population health improvement goals. Through Minnesota's SIM activities, the Minnesota Departments of Health and Human Services along with over 400 stakeholders, payers, providers, and community-based partners are actively engaged in advancing accountable care.

During the past several years, Minnesota's SIM funded activities have supported the project's five primary drivers and the original project aim. The collaborative efforts from a wide range of partners have helped us exceed many of the original goals related to payment and care delivery reform. As we prepare for the final year of the project, and look to move beyond the goals we had initially set for ourselves, Minnesota has identified the expansion of **health information use & exchange and value -base d payment models** as critical factors for our future success. Below, we outline Minnesota's recent and upcoming work in these areas, including both SIM-funded and non-SIM funded work. Ongoing federal guidance, alignment and support will continue to be important to these efforts.

## **Health Information Exchange**

[Minnesota's Interoperable Electronic Health Record \(EHR\) Mandate](#) required all hospitals and health care providers to have an interoperable EHR in place by January 1, 2015. This has been a critical lever that has helped Minnesota achieve near-universal EHR adoption within certain settings of care, but having an EHR is only the beginning. SIM funding was used to push us towards statewide interoperability, through support for [e-health use & health information exchange](#) (HIE) with a focus on providers in behavioral health, local public health, long-term and post-acute care, and social service settings. SIM also supported enhanced data analytic reporting tools and technical assistance for Minnesota's Medicaid ACOs, [the Integrated Health Partnerships \(IHPs\)](#). In addition, funds were used to examine the legal issues around Minnesota's privacy, security and consent management for electronic health information exchange and to offer guidance and resources to providers encountering barriers with e-health exchange.

Looking toward the future, additional commitment is needed from Minnesota's payer and provider community regarding alignment with Minnesota's HIE strategy and priority recommendations. Using policy levers, contractual arrangements, certifications and incentives, Minnesota must build the necessary consensus among payers and providers to enable priority HIE transactions for providers across the spectrum of care, beginning with Medicaid providers. A 2016 legislative requirement will explore the costs and patient impact of Minnesota's consent laws and provide recommendations for long-term HIE governance, policy, operations, technical infrastructure and finance. Minnesota will continue to support the implementation of the e-health Roadmap and a coordinated approach for health care and public health providers to submit data to the Minnesota Department of Health

With SIM funds supporting [providers' capacity to participate in the exchange of priority transactions](#), Minnesota will explore the use of federal 90/10 funding to promote the statewide expansion of health information exchange. A priority focus will be on the development of a Medicaid Provider Directory or shared services environment for priority statewide HIE transactions (ADT alerts/notifications, care summary exchange and analytic capabilities for defined social determinants of health). Long-term financial sustainability is critical to preserve and develop Minnesota's HIE investments.

## **Value Based Payment Models**

Minnesota launched its Medicaid ACO demonstration project in January, 2013. Six delivery systems began as [Integrated Health Partnerships \(IHPs\)](#) serving approximately 100,000 Medicaid beneficiaries. SIM investments have accelerated provider participation and expanded attributed populations. Today, nineteen IHPs provide high quality care to more than 342,000 Minnesotans and have saved approximately \$156 million compared to projected Medicaid spending. Effective January 1, 2017, additional provider systems are expected to join the IHP program.

Minnesota has also seen success with the implementation and advancement of [Minnesota's Health Care Home](#) model, which builds on a strong primary care foundation to ensure team-based, coordinated, patient centered care with collaboration between primary care and community resources. Almost 400 clinics are currently certified as a Health Care Home, enabling them to receive payments for care coordination services and ongoing support in their practice transformation efforts. A recently published independent evaluation [report](#) indicates that Health Care Homes providers and systems have produced savings over a five year period, while showing higher scores on core quality metrics than non-Health Care Homes.

Over the upcoming months, Minnesota will work with stakeholders to refine the IHP, Health Care Homes and other models to best position Minnesota's providers to participate in advanced payment models offered by other payers, including those at the federal level as well as population health initiatives.

We will also continue to incent providers to establish partnerships with a broad range of community partners, to more effectively address social determinants of health and achieve population health goals. It is critical to standardize metrics for quality, care delivery and payment, which must also have a clear cost and health benefit, in order to advance value-based payment models and population health models within Minnesota.

Again, thank you for this opportunity. Please contact Krista O'Connor ([krista.oconnor@state.mn.us](mailto:krista.oconnor@state.mn.us)), Minnesota's SIM Project Lead, with any questions related to this response.

Thank you.



**CMMI RFI Questions and Synthesis of Responses**  
From Members of the Community Advisory Task Force and  
Multi-Payer Alignment Task Force  
*October 2016*

**SECTION I. MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

*1. What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?*

Minnesota's robust and successful state-based initiatives, and the strong support from our task forces and grantees, collectively signal that there is strong interest in and support for reform efforts that address our state population needs and provide additional support to overcome challenges. Where these efforts can be done across payers, this helps concentrate focus and momentum for providers and policy makers and eases transitions for people as they move between payers. We have asked many of these questions, or variations of them, in recent RFIs for several of our programs, including the Integrated Health Partnerships and Health Care Homes programs; the responses here are generally consistent with the responses we have received through those other mechanisms.

*1a. What challenges do states face in achieving all payer alignment, including basic Medicaid Infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?*

Challenges mentioned by the task force include the competitive nature of health plans and health systems, and the unique challenges for self-insured employers who bear most of the risk for the insurance plans. Other barriers include lack of a statewide health information exchange and restrictive laws that hinder data sharing and **relevant sharing of data between providers**, particularly between providers in different EHR systems.

CMS should encourage and incentive states to align privacy regulations and health information interoperability. Specific to Medicare, members pointed out a lack of incentives that support quality or improved population health but don't lead directly to measurable savings. Difference in capitation rates for urban and rural populations were also cited as a barrier to alignment.

Nevertheless, members also mentioned need align quality measures, using national quality standards such as HEDIS. As one member stated, "... a provider's capacity to meet quality targets is limited; as a result, many providers focus on meeting the quality measures of the payers that

cover their largest populations.” Alignment should occur with the involvement of commercial payers, which will widen the base of support for alignment.

*1b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?*

A state-based initiative should include standardizations of quality measurements and data elements across all payers, a statewide HIE infrastructure to ensure timely exchange of high priority data elements or transactions that would eliminate gaps in care and ensure better coordination of care and the availability of technical assistance resources to support provider transformation. Standardization between the state and federal regulations is also recommended, especially in regards to privacy laws that affect the ability of providers and payers to share data and coordinate care. Participants in these future initiatives need to “...show measureable improvements in all aspects of the Triple Aim, including reduction of cost trends, care coordination, and quality.” Members also mentioned support for primary care as well as helping small behavioral health providers to stay financially solvent in an environment with increased downside risks to providers. Innovations such as the virtual Integrated Health Partnership and development of payment models that do not require face-to-face clinical visits for payment would “allow flexibility and drive innovation in care delivery.”

*1c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?*

While alignment of measures and models is crucial, it should be recognized that the Medicaid and commercial populations are different. These include differences in cost, covered benefits (including a wide range of health and human services and care providers), age, diagnoses, and income, which is an important social determinant of health. A lead organization will be necessary to coordinate between the different demographics and characteristics of members in public versus commercial insurance products. The task force suggested that the state could serve this role as an entity but not as a payer, and to align common payment around the state’s population health goals “rather than aligning across all payers and demographics.”

Members also mentioned balancing cost and quality, and understanding that multiple years may be needed to benefit from a particular initiative. The move towards APMs for Medicaid can be strengthened by encouraging commercial payers to move toward the same models. “Medicaid-population-only APMs will not be successful if providers are serving large numbers of commercial patients that are covered in a fee-for-service arrangement”—in which the provider receives more incentive for volume rather than value. Basic Health Plans should also be taken into account when developing APM.

*4 1d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?*

Medicare payment models and population health initiatives should be aligned with Health Care Homes and the Medicaid Integrated Health Partnerships. CMS should assure flexibility to meet the needs of different Medicare populations such as the elderly, new immigrants, and dual eligible individuals based on age or disability, and Medicare savings programs based on income.

Social determinants of health need to be taken into account with federal risk adjustment models and other federal policies, to account for specialized care needed for certain populations.

*1e. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?*

The state would need **at least three years**; although Minnesota would have a head start because of its efforts with SIM, any significant change would require time to implement, even with the support of stakeholders. Longer than three years may be required if changes to state law or rule are needed (for example, changes in privacy laws), or if new data collection mechanisms need to be built.

*1f. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?*

CMS should attempt to **standardize quality measurement across states**. Quality improvement directors from health plans and state government officials across multiple states could provide valuable input on metrics and evaluation. Further, each state's level of change could be **recorded from baseline measures as opposed to comparisons across states**. It is also critical to keep **beneficiaries and state population health as the focus** of the evaluation rather than tied exclusively to financial targets within a predetermined population. Finally, since CMS sees differences in benefits and reforms across states, this mechanism could offer **tool for giving states improvement ideas and insights**.

*1g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?*

First, CMS should consider the **unique challenges of Medicare populations and be flexible in adapting Medicare models** so that they can align more easily with other state models and initiatives. CMS should consider aligning **Medicare Advantage Star Ratings** with the State's Medicaid quality, population and patient experience measures. CMS should examine **overlap between Medicare Advantage Star Ratings, HEDIS, and measures developed for the commercial Exchange plans**. Second, CMS needs to ensure that any model that it proposes does not negatively impact successful work and **best practices already in place** for the state's members, providers, and health plans. For example, Minnesota is going through an **important transition from a cost-plan state to a Medicare Advantage plan in 2019**—affecting 250,000 Minnesotans—**timing should be considered**. Finally, **states should be given the option to choose the pathway** that best supports their unique communities, providers, and payers.

*2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.*

*2a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.*

The state's role is to lead the development of measures that are aligned across all populations. Incentives must assure that providers continue to **involve patients in the determination of treatment**. In order to make sure that providers are fully invested in achieving the Triple Aim, they must assume both **positive and negative financial risk**, with some degree of **risk stratification** based on social determinants of health and other population differences mentioned in the above comments. Data collection must include these factors in order to take them into account for alternative payment methodologies, and quality improvement initiatives or accountability metrics need to acknowledge the critical role of factors outside of the health care system that influence health.

**A statewide framework for HIE, with a focus on real-time access to high priority transactions such as admission, discharge and transfer alerts and continuity of care documents and the ability to connect providers across all settings of care, is critical. Infrastructure needs to be developed, either at the provider level or at a statewide level, that can facilitate integration of provider EHR and payer claims data, which is critical to effective care coordination across all providers.**

*2b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?*

This is an issue that impacts all providers and their partners, not just rural and tribal communities. The collection of the six **social determinant data elements** that the Minnesota SIM-led Data Analytics Subgroup recommended could be used: 1) mental health and substance use (current diagnosis or unmet need), 2) race, ethnicity, and language, 3) access to reliable transportation, 4) social services already being received, 5) housing status or situation, and 6) food insecurity. The use of **member-centered outcomes** are also important, e.g. reduced ER visits, increased preventive visits, incorporating dental and other ancillary services, alignment and coordination of services (e.g., case management, detox, mental health services, and jail service coordination). Each of these can then be measured to compare rural and tribal care against urban care, although it should be noted that **urban areas have similar challenges** in providing social services and addressing public health needs.

It is also important to have an **integrated delivery system**, where physical health, behavioral health, local public health and social services are included as partners and involved in the development of shared care plans, alongside making use of the symbiotic relationship between healthcare and county/tribe coordinated services. Finally, rural and tribal healthcare is facing **shortages of providers** so it's critical to start **leveraging technology (e.g. telehealth and telemedicine) and integrating new provider types such as community health workers and community paramedics into their teams**; providers can also consider **in-home visits and cell phones** as alternatives for diagnosis and treatment. These newer types of care can help move away from institutional-focused care, where much critical-access care in Minnesota is currently still provided.

State programs such as the IHP and HCH models can support and facilitate the inclusion and measurement of social determinants of health, and serve as vehicles to promote broader partnerships with community and social services providers that can help to address social determinants, in both rural and urban areas. These are among the areas that recent RFIs for these programs sought input on, and stakeholders were broadly supportive of using these care delivery and payment reform mechanisms as levers to promote this type of change.

*2c. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?*

Urban providers can benefit from **clarified attribution and consistent risk adjustment mechanisms across payers**,—allowing for flexibility and support in health information exchange, the use of telehealth, and data availability. There is a tension in the market between the idea of a **provider caring for a defined population** and **consumers wanting choice** in the marketplace. **With ACOs, there needs to be assignment mechanisms based on outcomes and financial risk.** APMs are often designed for the provider rather than the individual, which is not always in-line with patient-centered care; providers in accountable care models often still work with their patients the same way they did in a fee-for-service system.

**Care coordination is critical** to addressing this issue, including helping address complex patients across wider geographic areas. There are currently **different approaches to paying for care coordination**—adding on to fee-for-service rates or viewing it as implicitly included in existing

Payments to providers. In either case, there can be a divide between the health providers that benefit most with coordination; thus, it is important to consider **how those costs and benefits are distributed**. For example, a primary care clinic may carry the cost for coordination but a hospital may be the beneficiary due to reduced Emergency Department visits or admissions.

In addition, **connecting through HIT**, as part of care coordination and population management, would allow the providers to focus on the patient and be able to provide optimal care and outcomes. However, state approaches to health information exchange and HIT differ in terms of governance, oversight requirements, and (particularly in Minnesota's case), consent requirements associated with health information exchange, making exchange of information across state lines complicated. Urban providers, like rural ones, can also **support collaborations with social service providers**, including partnerships with schools, community organizations, and social service agencies.

*3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.*

*3a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?*

APCDs are valuable data tools for studying delivery system reform and population health improvement efforts, informing health policy development and increasing transparency.

Minnesota's APCD does include both Medicare and Medicaid data. However, in Minnesota the legislature has regulated access and use of data tightly to ensure privacy of information and protect against shocks to provider and insurance markets, resulting in limits on the use of this data source outside of a higher-level research studies led by the State.

Post-adjudicated claims data, by its nature, involves significant time lags before data become available. While states can take certain steps to reduce this time lag, and can make use of existing algorithms to develop and disseminate key metrics about the performance of the delivery system, a stronger source of timely data for managing patient panels and developing predictive analytic models for reducing total cost of care is the regular (often monthly) data analytics feeds that payers transmit to providers with whom they contract for total cost of care or other ACO-like models.

*3b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and healthcare data; appropriate measures)?*

Minnesota has the availability of reliable and timely data sources, such as an APCD, our IHP Partner Portal, SQRRS, etc. In addition, State staff and other key stakeholders have expertise within specific contexts to use the data, however, capacity will need augmentation in order to fully



take advantage of the opportunities to tie payment and social determinants to health outcome measures.

*3c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?*

Please see answer 3a.

*3d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?*

Please see answer 3a.

*3e. What support can CMS provide to improve states' access to reliable and timely data?*

Please see answer 3a.

*3f. How can CMS support improve access to and linkage with health outcomes measures data?*

Please see answer 3a.

*3g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?*

*3h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?*

While there is a large amount of data available, much of it is **not actionable to adequately address population health**. One approach suggested by the task force would be to explore using selected Medicare metrics, such as Medicare Spending Per Beneficiary, as part of a statewide core set of metrics to benchmark against or report on. It could also be helpful to align and use practical and actionable metrics within the **Statewide Quality and Reporting Measurement System**. Finally, Minnesota has a high level of collaboration among stakeholders; this is an asset and the state needs to continue its work on **addressing core data elements to be collected by all key stakeholders**, including social determinants of health.

## SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

*1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).*

*2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would*

*states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?*

**Yes**, standardization and participation in such interventions is likely in Minnesota. It is interesting to note that this question and question 1 in this section have a **research orientation, rather than model testing**; it may be worthwhile for CMS to partner with sister organizations under HHS that do more research, like AHRQ. When conducting randomized evaluations, there are **inherent delays in acting on the findings**, which is not effective for innovation, rapid cycle improvements and quality improvement work.

*3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.*

Through Minnesota's SIM-led Data Analytics subgroup work, we have identified **six social determinant data elements that should be collected and/or shared in care settings as a way of acknowledging the broad range of non-medical factors that can influence health outcomes**: 1) mental health and substance use (current diagnosis or unmet need), 2) race, ethnicity, and language, 3) access to reliable transportation, 4) social services already being received, 5) housing status or situation, and 6) food insecurity. Minnesota is committed to continuing to evolve its existing care delivery programs, such as HCH, to incorporate these social determinants into community partnerships, referral networks, and risk stratification, but there is a need for additional research into the most effective way to structure this work within communities for the best results, to measure success, and to financially sustain progress. There is also a need to develop additional evidence related to mental health transitions between inpatient care and community support.

*4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.*

States could focus on **in-home services, transportation, and support in transitions**. It's important to **collect data on social determinants to better coordinate services** to address disparities. One strategy for moving this work forward would be to implement the six social determinants data elements mentioned above, and to evolve care delivery models to include focused work related to these social determinants factors. This issue continues to be important to Minnesota stakeholders, and one that they are actively working on.

### **SECTION III: STREAMLINED FEDERAL/STATE INTERACTION**

*1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their*



*delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?*

Minnesota is a leader in **Accountable Communities for Health** and in authentic **multi-sector collaboration**. In the state, many organizations have been **willing to embrace demonstrations**, including being at risk to take on innovation. Often **being involved with one intervention means ineligibility for another intervention/demonstration**. These types of restrictions result in barriers when the boundaries are not clear. It can also be challenging when there are a number of initiatives or efforts co-occurring. State and provider capacity is stretched and momentum toward a particular objective weakened in order to understand, assess and or participate in additional alternative reform efforts. Continued flexibility to pursue state goals on timelines that are reasonable for the state is needed.

*2. How can CMS/HHS better align in order to support state delivery system reform efforts?*

First, commercial, Medicare, and Medicaid **payment models** should align. Second, it is vital to **coordinate all federal technical assistance resources**—such as QIN-QIOs, PTNs and SANs, HIINs, AHCs.

## **Response to State Innovation Model Concepts RFI**

THE MINNESOTA DEPARTMENTS OF HEALTH AND HUMAN SERVICES, ALONG WITH SUPPORT FROM THE FOLLOWING MEMBERS FROM MINNESOTA'S COMMUNITY ADVISORY AND MULTI-PAYER ALIGNMENT SIM TASK FORCES, SUBMIT THE ATTACHED RESPONSE TO THE CENTER FOR MEDICARE AND MEDICAID INNOVATION REQUEST FOR INFORMATION ON STATE INNOVATION MODEL CONCEPTS.

### **Community Advisory and Multi-Payer Task Forces**

<b>Name</b>	<b>Organization</b>	<b>Title</b>
Charles Abrahamson	HealthPartners	VP of Network Management and Provider Relations
Courtney Baechler	Allina	VP, Penny George Institute for Health and Healing
Galen Benson	Minnesota Management & Budget, SEGIP	Assistant Director, Employee Insurance Division
Karen Chapin (as individual, not representing the MN)	University of Minnesota	Health Programs Manager
David Cook	Zumbro Valley Health Center	CEO
Bobbi Daniels	University of Minnesota Physicians	Chief Executive Officer
Renee Frauendienst	Stearns	Public Health Division Director
Paul Kleeberg	Aledade	Medical Director
Rahul Koranne	MN Hospital Association	Senior Vice President for Clinical Affairs and Chief Medical Officer
Jonathan Lundberg	Ebenezer	Chief Operations Officer
Jennifer Lundblad	Stratis Health	President and CEO
Beth Monsrud	UCare	Senior VP President and CFO
Nathan Moracco	DHS	Assistant Commissioner, Health Care Administration
Carolyn Pare	MN Health Action Group	President and CEO
Jim Przybilla	Prime West Health	CEO
Stephanie Radtke (as individual, not representing Dakota County)	Dakota County	Deputy Director of Community Services at Dakota County
Brett Skyles	Itasca Medical Care	CEO
John Soghigian	Consumer	N/A
Catherine VonRueden	Essentia Health	VP, Payer Contracting and Strategy

## HEALTH POLICY AND ANALYTICS

Kate Brown, Governor

October 28, 2016 Dr. Patrick Conway  
Deputy Administrator for Innovation & Quality  
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### **Oregon Health Authority Comments in Response to Request for Information (RFI) on State Innovation Model Concepts**

Dear Dr. Conway:

Oregon is pleased to submit this response to the Center for Medicare and Medicaid Innovation's (CMMI's) Request for Information on State Innovation Model Concepts. Specifically, we are addressing Section I, *Multi-payer State-based Strategies to Transition Providers to Advanced APMs* and Section III, *Streamlined Federal/State Interaction*.

Since launching our health system transformation efforts in 2012, Oregon has had many successes; however, we have additional work to accomplish toward our goal of meeting the triple aim for all Oregonians. As a natural follow-up to our State Innovation Model (SIM) grant, and in conjunction with our 1115 waiver renewal request recently submitted to the Center for Medicare and Medicaid Services (CMS) and our forthcoming Comprehensive Primary Care Plus (CPC+) program implementation, the Oregon Health Authority (OHA) has a vision of long-term, state-wide, sustainable multi-payer payment reform. A comprehensive, multi-payer payment-reform initiative is a natural continuation of the work we have accomplished under SIM, but without SIM resources, providing the same level of technical assistance and resources critical to this effort will not be possible. Implementing sustainable payment reform will prevent continued reliance on grants and short-term initiatives. In addition, broad-scale, multi-payer payment reform benefits providers entering into models that could qualify as Advanced Alternative Payment Models (APMs), which supports Medicare Access and CHIP Reauthorization Act (MACRA) goals.

Below we lay out our vision for comprehensive payment reform in Oregon, and identify a number of areas where CMS assistance would be instrumental in helping us achieve this vision.

#### **Oregon's Payment Reform Vision**

Oregon has a number of payment-reform initiatives—either currently underway or in the early planning stages—that we envision combining into broad-scale, multi-payer (including Medicare) delivery and payment reform effort. This approach will support better health outcomes for Oregon's entire population through alignment of care delivery and payment, using the CPC+ program as foundation. Specifically, initiatives focused on primary care, behavioral

health, oral health, coordinated care organizations, a health/housing pilot, and the dual Medicaid/Medicaid population will be woven together into a comprehensive payment reform effort.

Not only are a number of the strategies identified supported through our SIM grant, but they are also aligned with Oregon's recently submitted waiver renewal goals, which are:

1. Build on transformation of Oregon's Medicaid delivery system with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance-driven system with the goal of improving health outcomes and continuing to bend the cost curve;
2. Improve the social determinants of health and health equity across all low-income, vulnerable Oregonians with the goal of improving population health outcomes;
3. Commit to an ongoing sustainable rate of growth that includes the 2 percent test with penalties and an integrated global budget that promotes increased spending on health-related services and advances the use of value-based payments; and
4. Establish supportive partnerships with CMS to expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual eligible members.

Below we provide an overview of these payment reform initiatives and the types of assistance that Oregon would find useful to implement long-term, comprehensive, sustainable payment reform.

Primary Care: In 2015, the Oregon legislature passed SB 231, which mandated a multi-stakeholder Primary Care Payment Reform Collaborative that OHA has convened since April 2016. The Collaborative's goals are to: (1) identify best practices that support primary care through technical assistance, methods of reimbursement, and evaluation; (2) work together to seek alignment and agreement around next steps to support sustainable primary care transformation and achieve the triple aim; and (3) provide an opportunity for the group to identify and work on shared interests and activities to support primary care transformation. The Collaborative has recently worked on recommendations related to primary care payment to be presented to the Oregon Health Policy Board—which serves as the policy-making and oversight body for the Oregon Health Authority—that may be turned into legislation.

The month the Collaborative launched, CMS announced the Comprehensive Primary Care Plus (CPC+) opportunity, a follow-up to the Comprehensive Primary Care Initiative (CPCI) in which Oregon is participating. Many Oregon payers, including OHA, applied, and Oregon was recently accepted as a CPC+ region. The Collaborative composition is broader than the CPC+ program, which is not open to federally qualified health centers, rural health centers, pediatric clinics, and behavioral health clinics. These exclusions are problematic because they hinder both administrative simplification and consistent application of metrics across all payers and providers. Consequently, through Collaborative conversations, it was decided that Oregon would extend the CPC+ model to all practice types. Looking forward, it is expected that the Collaborative will serve as a central convening table for those participating in CPC+ and beyond, bringing together all payers and practices in an effort to align primary care payment reform activities in the state.

Behavioral Health: Concurrent with these primary care payment reform initiatives, OHA has convened a Behavioral Health Collaborative focused on improving Oregon's behavioral health system with an emphasis on cross-agency collaboration and improved health outcomes. The Collaborative includes a payment and reimbursement workgroup that is currently proposing a model for Value-based Payments (VBP) for behavioral health services across settings

of care. The Behavioral Health Collaborative and the Primary Care Payment Reform Collaborative are connected via common stakeholders and staff.

Coordinated Care Organizations: As presented in Oregon's waiver renewal application, Oregon has learned lessons from the last four years of transformation that indicate where the state needs to concentrate its efforts moving forward. Consequently, one of the key goals laid out in Oregon's application is an ongoing commitment to a sustainable rate of growth that includes an integrated global budget that promotes increased spending on health-related services and advances the use of VBPs. Specifically, the State's CCO contracts do not require CCOs to enter into a minimum percentage of VBP arrangements, and at present, many CCO payments to providers are made through fee-for-service arrangements. Accordingly, Oregon will submit to CMS a VBP plan that describes how the State and CCOs will achieve a specific percentage of VBP payments by the end of the demonstration period.

Coordinated Health Partnerships: Within Oregon's waiver renewal application, we propose to create a five-year pilot program, the Coordinated Health Partnerships (CHPs), for high-risk individuals and families with unstable housing. Through the CHPs, high-need individuals and families would be offered a combination of housing, care coordination and supportive services through a community-based integration hub to improve health outcomes and reduce Medicaid costs. The CHPs will test new models to increase collaboration and coordination among a broad range of entities, including CCOs, local hospitals, community-based organizations, and counties to address the social determinants of health. This unique cross-sector model, with its focus on care transitions, social service referrals, and affordable housing, will require new models of payment. While planning for the CHP payment model is still early, one thought is that the CCO VBPs identified above could be leveraged to further encourage CHPs to address health-related social needs.

Two other areas that Oregon intends to incorporate into a comprehensive payment system—even though there is no current or planned initiative in either area—are oral health and the dual Medicare/Medicaid population.

Oral Health: Dental benefits were folded into Oregon's CCOs' global budget a year after the CCOs launched. The heavy lift of integrating behavioral health first, along with the groundbreaking effort of integrating physical, behavioral *and* dental health, has made for slower progress in full dental integration and the APMs necessary for integration. It is clear that long-term, sustainable payment reform needs to incorporate the dental health system.

Medicare/Medicaid Population: Comprehensive, multi-payer payment reform also requires more of a concerted focus on incorporating Medicare. While Medicare is a foundational component of CPC+, we also have a vision for a Dual Medicare/Medicaid pilot project that would integrate services for disabled populations via Patient Centered Primary Care Homes (PCPCH) or behavioral health homes, which would serve as an element of our broader payment reform plan. We recognize this effort would entail a separate waiver and thus could be outside the scope of a comprehensive payment reform plan to be implemented in the near future.

## **Requests of CMS**

Below we present a number of suggestions for CMS assistance that would help us achieve our payment-reform vision, as well as suggestions for improved interactions between CMS and states.

### Section I: Multi-payer State-based Strategies to Transition Providers to Advanced APMs

Ideally, Oregon will weave the existing and planned payment reform initiatives identified above into sustainable, multi-payer reform effort. In order to achieve this vision, Oregon would welcome CMS support in the following areas.

**1) Support to develop a comprehensive plan for long-term, sustainable payment reform.**

While Oregon has a vision for a robust payment system, we would greatly benefit from a national expert to help us develop a concrete plan that weaves together the initiatives identified above into an actionable framework. For example, it will be important to incorporate hospitals into the plan to ensure Medicare is a key component of the comprehensive initiative.

**2) Resources to develop a total cost of care for the entire health system.**

To accurately assess the impact of the comprehensive payment reform and to encourage participation of a broad range of stakeholders, Oregon would appreciate expertise to help us model the total cost of care for the entire health system. We recognize the need to expand CPC+'s care management fee and pay-for-performance approach to the entire system. Such analysis would also allow us to capture key pieces of the delivery system, such as the cost of transitional care and hospitals, which would ideally bring these entities into the conversation. In addition, in alignment with our waiver renewal, our total cost of care analysis would ideally move upstream to incorporate the costs of housing and other means of addressing the social determinants of health.

**3) Convening of payer and provider stakeholders to achieve agreement on the payment reform plan.**

The SB 231 Primary Care Payment Reform Collaborative facilitator supported through SIM funds has been invaluable in keeping the primary care payment reform conversation aligned and moving forward. Since SIM support for this facilitator will end in December 2016, receiving additional resources to support Collaborative facilitation would be useful.

Further, we anticipate needing to convene a multi-stakeholder collaborative comprised of a broad range of stakeholders within and beyond the health system to achieve the vision laid out in the payment reform plan. Regular meetings between representatives of, for example, our primary care and behavioral health collaboratives, the CCOs, the oral health community, hospitals, and community partners such as housing would be essential to ensure success. We would welcome CMS resources for this endeavor.

**4) Support for data aggregation for quality metrics alignment.**

During the 2015 legislative session, the Oregon legislature passed SB 440, which calls for alignment of performance metrics across state health care programs to promote coordinated care and improved health outcomes and help reduce costs. This metrics alignment process—which is closely connected with the Oregon CPC+ program—will begin in January 2017, and would ideally apply to the entire health system in support of comprehensive payment reform. An essential element of an effective metrics alignment process is data aggregation, and Oregon hopes to incorporate a data aggregation method modeled after a state such as Colorado. Data aggregation is a resource-intensive endeavor, and CMS resources for Oregon's data aggregation activities could facilitate bringing other partners to the table.

**5) Additional OHA staff to implement Oregon's payment reform plan.**

Executing comprehensive payment reform will require additional OHA staff to form an OHA payment reform management team. New initiatives such as oral health payment reform identified above will require additional staff. In addition, staff will be needed for many of the activities identified above, such as overseeing the total cost of care analysis; staffing the comprehensive multi-payer collaborative; and managing the data aggregation process.

**6) Support for CCOs to reach their APM requirements.**

As explained above, per Oregon's waiver, Oregon is planning for CCOs to have additional APM requirements. We have learned that there is a wide range of ability and expertise within CCOs to develop and implement APMs. Oregon has been using SIM dollars through the Transformation Center to support APM implementation for more half of the CCOs over the past few years; however, with the impending end of SIM dollars, such support will not be possible. CCOs could benefit from consultant expertise to help them design and execute their APMs, as well as resources necessary for data analysis activities essential to successful APM development.

**7) Support to ensure practice s qualify for MACRA.**

Finally, to achieve Oregon's payment reform vision, it is important that as many practices as possible qualify for MACRA's Quality Payment Program (QPP). CMS support that would help ensure this goal is reached include technical assistance to non-CPC+ practices; support for workflow modifications necessary to implement APMs; and resources that ensure the adoption of certified EHR technology required through the QPP occurs successfully.

**8) Technical assistance and support for CPC+ payers.**

Finally, ensuring success of a comprehensive payment reform initiative first requires that CPC+ is implemented successfully, since the program will serve as a foundation for our reform efforts. Through our experience with CPCI and conversations with current CPC+ payers, it is clear that two areas of support would be useful. First, while practices will benefit from CMS-supported technical assistance, there is no plan for payers to receive technical assistance. In Oregon, many of the CPC+ payers, including the 13 CCOs that did not exist when CPCI was launched, are new to primary care payment, and would greatly benefit from any technical assistance CMS could provide. In addition, while CMS is supporting facilitation for convening of CPCI payers, this is not the case for CPC+, meaning payers are currently trying to work out the contracting mechanisms and identify funding sources for this vital activity. Consequently, we would appreciate CMS support for payer facilitation.

**Section III: Streamline Federal/State Interaction**

Oregon has valued the extensive support provided through our SIM grant—we would not have realized the significant successes in our delivery system transformation efforts without it. We have appreciated our partnership with the Center for Medicare and Medicaid Innovation and have found our SIM Program Officers and technical assistance providers to be very helpful and responsive.

We do have two suggestions for improved CMS/state partnerships based on our SIM experience, both of which are related to reporting:

1. **Clear and consistent report guidelines and templates.** For example, Oregon's quarterly report requirements, such as those related to content, have changed over time, and modifications have periodically been made at the last minute. For future CMS/state partnerships, consistent report templates would be extremely helpful.
2. **Streamlined and coordinated requirements for providing updates.** We have found that we sometimes report the same information on our SIM progress to multiple CMMI audiences; for example, we often provide the same updates to our SIM evaluation team and technical assistance team. Streamlining the audiences for these updates would increase efficiency.

In addition, we have a suggestion that extends beyond our SIM experience.

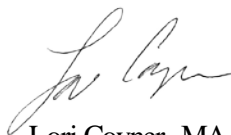
3. **Explanation of how CMS initiatives work together.** CMS frequently launches new opportunities and initiatives to support health system reform. It is at times unclear how these initiatives are connected or complement each other. Oregon would appreciate CMS sharing a detailed explanation of how these initiatives are linked and form a cohesive strategy.

We appreciate the opportunity to share Oregon's vision for long-term, sustainable payment reform and the ways in which CMS could help us achieve our vision and streamline federal/state interactions. We look forward to partnering with CMS on the important work of payment reform.

Sincerely,



Leslie M. Clement, MPA  
Director of Health Policy & Analytics



Lori Coyner, MA  
State Medicaid Director



October 28, 2016

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue SW  
Washington, D.C. 20201

**Re: Response to Request for Information on State Innovation Model (SIM) Concepts**

Dear Administrator Slavitt:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to respond to the above-referenced Request for Information. NRHI is a national organization representing over 35 Regional Health Improvement Collaboratives (RHICs). Within their communities, each of our members is working to transform the healthcare delivery system and achieve the Triple Aim: improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per-capita cost of healthcare.

Below we provide some background on RHICs, including the ways in which RHICs are collaborating with state governments, and recommendations on how SIM work could be better connected with RHIC activities.

**I. Background on RHICs**

A RHIC is a non-profit organization based in a specific geographic region that:

- (1) Is governed by a multi-stakeholder board that must have representation from four types of stakeholders: (a) health care providers (hospitals, physician groups, physicians, home health agencies, nursing homes, clinics, etc.); (b) health care payers (private health insurance plans, state Medicaid agencies paying directly for care, etc.); (c) healthcare purchasers (employers, unions, retirement funds, and government entities); and (d) health care consumers or consumer organizations;
- (2) Has a mission is to improve healthcare quality and value through an active program of quality measurement and public reporting, or an active program of quality improvement, or both; through a collaborative effort of healthcare providers and other stakeholders; and

- (3) Helps stakeholders in the community identify opportunities for improving the health and healthcare of the community, and facilitates planning and implementation of strategies for addressing those opportunities.

NRHI members have footprints extending into 25 states. Some states have more than one RHIC, and some RHICs span multiple states. Nineteen are statewide, and 15 are regional. RHICs convene providers, provider organizations, commercial payers, employers, consumers, and other relevant stakeholders to build consensus on strategies and techniques to improve health outcomes and reduce health spending.

Several of our members are partnering with states in a number of ways, helping convene key stakeholders and offering data and analytics to drive health care reforms. These partnerships have yielded promising results, but there remain vast untapped opportunities for states and RHICs to collaborate and foster productive partnerships across public and private sectors. Through SIM initiatives, CMS can promote this collaboration and encourage states to leverage RHIC resources and expertise.

## **II. Encouraging sustainable, multi-payer models that advance population health and financial accountability**

### *a. What factors are essential to the success of multi-payer delivery system reforms?*

We wish to highlight two key factors that we believe are essential to the success of multi-payer delivery system reforms: (1) having a trusted convener; and (2) access to robust data.

To effectuate reforms at a state-wide level, states must coordinate with all relevant stakeholders, and need strong partners to develop and advance specific strategies for health care transformation on the ground. An effective convener is therefore essential to the success of multi-payer delivery system reforms. RHICs are trusted local conveners and on-the-ground implementers of delivery system and payment reform across all payers and stakeholders. Their multi-stakeholder composition, plus their history of success in their regions, has facilitated the development of strong relationships with clinicians and others in the healthcare community. States should leverage these existing relationships in order to meet SIM objectives.

Robust data is also essential to reform goals, because it is impossible to measure success without it. Having comprehensive data depends on the contributions, collaboration, and cooperation of a broad array of stakeholders. In addition, the use of data requires agreement on rules for its use, which necessitates building trusted governance and operating models. Finally, working with health care data is resource-intensive, and creating these partnerships can leverage infrastructure and resources to make data available in more effective and efficient ways. Through partnerships with private stakeholders, states and the federal

governments, RHICs have access to transformative data (claims, clinical and patient experience data) from multiple payers. RHICs have also developed the analytic capabilities to measure and report on performance, and work with providers to understand and act on the information.

*b. How can CMS meaningfully evaluate unique models across states?*

Without a core set of performance metrics, it is difficult if not impossible for CMS (as well as employers, consumers and payers) to evaluate different models and determine which model is producing better outcomes. CMS should ensure that any new SIM initiatives incorporate a core number of high-priority measures, including patient-reported outcome measures.

*c. What tools and resources would payers, providers or states need to execute financial incentives for improving population health outcomes?*

The combined purchasing power of states and private payers can be a powerful tool in advancing reform. But to effectively use this tool, states and private payers need to align incentives such that providers adopt reforms for their entire patient population, instead of particular segments of those populations. To that end, there needs to be a set of standardized measures that enable meaningful benchmarks and allow for comparisons across regions. A lack of alignment will lead to a lack of accountability.

*d. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks, monitor Medicare and multi-payer total cost of care trends, and calculate quality and population health measures on a multi-payer basis?*

As mentioned above, good, reliable information is critical for improvement, and this data resides with many payers and providers. Most RHICs have access to multi-payer claims databases and many combine claims data from multiple commercial payers and Medicaid to measure and analyze the quality and cost of healthcare in their communities. Ten of our members are Qualified Entities and have access to Medicare claims data, having been deemed, through a rigorous approval process, capable of combining Medicare claims data with claims data from other sources for performance measurement and reporting purposes. Qualified Entities and other RHICs can and should be leveraged to measure total cost of care across payers, and calculate other population health measures under SIM initiatives. Many RHICs also have the expertise and technology needed to attribute patients correctly to providers, groups, plans, etc. This is critical to the success of accurate private and public reporting. In some cases SIM dollars have been used to develop duplicative or redundant data and reporting systems that compete with existing successful nonprofit community resources. This competition leads to stakeholder frustration, fatigue and often time redundant inefficient outcomes.

### **III. Assessing the impact of specific care interventions across multiple states**

NRHI supports a SIM initiative that would assess the impact of specific care interventions across states. A standardized approach would enable measure alignment and promote accountability. As CMS considers this approach, we encourage it to consider partnerships with RHICs, including Qualified Entities that would leverage RHIC's existing data resources and analytic capabilities as well as their collaborative stakeholder networks.

### **IV. Conclusion**

We appreciate the opportunity to comment on this Request for Information, and look forward to working with CMS and states on future SIM initiatives.

Regards,

A handwritten signature in black ink, appearing to read "Elizabeth Mitchell", written over the printed name.

Elizabeth Mitchell  
President and CEO

Center for Medicare and Medicaid Innovation  
7500 Security Boulevard  
Baltimore, MD 21244

October 28, 2016

## Request for Information on State Innovation Model Concepts

To Whom It May Concern:

Thank you for the opportunity to provide comments regarding the Centers for Medicare and Medicaid Service's (CMS) State Innovation Models initiative.

Blue Cross Blue Shield of Michigan (BCBSM) is a strong advocate for innovative payment models and has a long history of pioneering engagement with providers to improve care for patients throughout Michigan. In the last 10 years our Value Partnerships programs have prevented \$1.4 billion in health care cost while improving the quality of patient care.

BCBSM is participating in an array of CMS demonstrations and initiatives: Our HMO, Blue Care Network, is participating in the Center for Medicare and Medicaid Innovation's (CMMI) Oncology Care Model, BCBSM has been approved to participate in CMMI's Comprehensive Primary Care Plus (CPC+) demonstration, and we are heavily invested in the success of Michigan's State Innovation Model.

BCBSM was also a strong supporter of Michigan's application for the Multi-Payer Advanced Primary Care Demonstration project and we were elated that Michigan was selected for this program in 2010. This CMS demonstration project became the Michigan Primary Care Transformation, or MiPCT.

MiPCT has been very successful. In the evaluation required by CMS, Research Triangle Institute found that the demonstration saved Medicare \$336 million, with a positive Medicare return on investment of fees of \$8.64, and provided \$110 million in additional funding for care management and care transformation to Michigan providers. Care managers are the core to the success of the program, and the primary mechanism for cost savings.

Ideally, MiPCT would have been extended and expanded upon – indeed, BCBSM and Priority Health remain committed to the program, and the state of Michigan is ensuring Medicaid will continue to support. But as a demonstration project, MiPCT is slated to end on December 31, 2016. As a result, providers, the state of Michigan and the participating private payers are searching for alternatives to

maintain the Medicare funding for care managers and ongoing practice transformation that MiPCT is providing.

While we are hopeful that the State Innovation Model, and the various approaches that are available, including CPC+ and the state customized approach, will ultimately afford Michigan the opportunity to maintain its current progress on care transformation, we believe that the process to continue and build upon a program that has clearly demonstrated effectiveness should be more straightforward. We are concerned that the current process of moving from one demonstration to the next has created a dynamic that is unnecessarily complicated and uncertain, and may leave practices with fewer resources to maintain their trajectory toward care transformation. In the pursuit of newer innovative approaches, the future of current, proven innovative efforts is put at risk.

We draw an analogy to CMS's approach on bundled payments, where CMS is actively and intensely evaluating an array of bundled payment approaches. Once CMS identified that the bundled payment initiative for hip and knee replacements was leading to positive results, CMS moved to make it permanent.

We encourage CMS in the future to take a similar approach with state innovation models. If a model, like MiPCT, is demonstrating effectiveness, CMS should work with the state, physician organizations, health systems and private payers involved in the model to collaboratively determine an approach to make the cost savings and the systemic improvements permanent.

We understand that in many states providers and payers are in relatively early stages of exploring and implementing advanced payment models. In those states it makes sense to offer opportunities to engage in CMS-run alternative payment models on a selective basis to gain experience and test models. However, there are some states such as Michigan that have a substantial majority of primary care and specialist physicians with longstanding experience in accountability for practice transformation, practice integration and practice performance (through value based reimbursement), so it is a step backward for Michigan clinicians to rely on CMS demonstration projects that may have limited opportunities for participation.

When a state has already broken substantial ground in value based reimbursement, as has Michigan, we believe it would be better to offer inclusive opportunities so that CMS joins in the robust efforts of other payers that are already in a relatively advanced state.

Please let us know if you have any questions. We would be happy to discuss further at your convenience.

Sincerely,

Thomas Simmer, MD

Senior Vice President & Chief Medical Officer



## Department of Health

**ANDREW M. CUOMO**  
Governor

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**SALLY DRESLIN, M.S., R.N.**  
Executive Deputy Commissioner

October 28, 2016

[SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

VIA ELECTRONIC MAIL

RE: Request for Information on State Innovation Model Concepts

Dear Acting Administrator Slavitt:

Attached please find New York State's response to the State Innovation Models (SIM) Request for Information (RFI), issued in September.

New York is capitalizing on the opportunity to respond to the SIM RFI to further articulate its statewide plan to evolve toward a healthcare system better positioned to achieve the Triple Aim. This response also represents the State's redoubled efforts to better align and coordinate its own health transformation efforts. Further, this response represents the collaboration of the NYS Innovation Center, the Office of Quality and Patient Safety, the Office of Health Insurance Programs, the Office of Public Health, and the Department of Financial Services, and is further inclusive of feedback and comments from key external stakeholders.

As a SIM Model Test state also implementing several other CMS initiatives including the Delivery System Reform Incentive Payment (DSRIP) program, Comprehensive Primary Care Plus (CPC+), and the Transforming Clinical Practice Initiative (TCPI), we appreciate the opportunity to comment, and welcome follow-up discussions to continue to advance and align these efforts.

Sincerely,

A handwritten signature in dark ink, appearing to read "Anne Schettine".

Anne Schettine, Deputy Director  
Office of Quality and Patient Safety  
Principal Investigator, New York SIM



Department  
of Health

# New York State response: CMMI RFI on State Innovation Model Concepts



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## A. INTRODUCTION

New York's State Health Innovation Plan (SHIP) is focused on achieving the "Triple Aim" for all New Yorkers: healthier people, better care, and smarter spending. Achieving this will require a fundamental change in how healthcare is delivered in the State: from fragmented systems of care with poorly aligned incentives to a more integrated system where providers are focused on all three aspects of the Triple Aim, practice not only patient-centered care but whole-person care, and coordinate care across the care continuum.

Healthcare providers cannot bring about this change alone, however. The entire healthcare industry, including payers, consumers, regulators and legislators, public health agencies, community-based organizations, and health information technology organizations must all contribute to the effort. The State of New York (hereby referred to as "The State") is taking the opportunity presented by the Center for Medicare and Medicaid Innovation's (CMMI's) Request for Information (RFI) on State Innovation Model (SIM) Concepts to articulate its plan to evolve toward a healthcare system better positioned to advance the Triple Aim. This response also represents the State's redoubled efforts to continue to align and coordinate its health transformation efforts, in particular among Medicaid and other State agencies.

The State's recommendations track against four guiding statements:

- 1. Multi-payer scale and alignment are critical to transformation**
- 2. Fundamental change requires consistent focus and support over time, not just a proliferation of innovation**
- 3. Transformation requires actionable insights driven by data that are comprehensive, transparent, and relevant**
- 4. The public sector at both the State and Federal levels should continue to take an active leadership role, and commit to a step-change improvement in alignment and collaboration**

In the following sections, we will describe each guiding statement and its rationale in more depth, and outline proposed policies at a state and federal level that follow from the guiding statements.

*The guiding statements and policy proposals, which articulate the State's vision for health transformation in New York, are not precisely aligned with each of the RFI questions. However, together they address the ones the State views as most critical. Our response to the RFI can be mapped to the RFI sections as follows:*

- *State Statement 1: RFI Section I (Multi-payer state-based strategies to transition providers to advanced Alternative Payment Models)*
- *State Statement 2: RFI Section II (Assess the impact of specific care interventions across multiple states), with relevance to both Sections I and III*
- *State Statement 3: RFI Sections I and II*
- *State Statement 4: RFI Section III (Streamlined federal / state interaction)*

*Each of our policy proposals has also been mapped to specific questions in each of the RFI sections.*

## B. POLICY PROPOSALS FOR EACH GUIDING STATEMENT

### 1. Multi-payer scale and alignment are critical to transformation.

Policy proposals summary

- Program alignment: The State will work to align DSRIP, APC, and APM parameters to enable sufficient consistency among multi-payer value-based programs and reconcile Medicare and Medicaid value-based payment programs for the total spectrum of care to the extent practicable.
- Public payer influence: Medicare and Medicaid should be leaders in New York's multi-payer APC program, both through direct participation and encouraging private payers and providers to participate.

Providers need transformative payment models to align across a substantial proportion of their patients, not an uncoordinated mix of models applied differently by each payer. While payers' programs do not need to be the same, they need to track consistently enough to a common patient-centered framework for transformation. This framework must include:

- Prospective investments conditional on making progress toward a generally agreed-upon care model;
- Common measures that are sufficiently aligned to accountability for quality and resource utilization, with a defined path to payment based on outcome measures; and,
- Coordinated timelines that account for the pace and timing of meeting expectations across programs.

Primary care, which has a central role in achieving the Triple Aim, exemplifies the need for multi-payer scale. In New York State, where a majority of primary care practices have fewer than five practitioners, and adoption of electronic health records (EHRs) is only 40%<sup>1</sup>, the investments needed to change healthcare practices are significant. Providers often face multiple sub-scale, value-based programs, each measuring and paying differently, with an expectation for unfunded, upfront investments producing little return for many years. Most, particularly smaller independent providers, would not be able to tolerate the financial risk involved.

The State is driving two major statewide programs centered on transforming healthcare delivery and payment in New York: the Medicaid-based Delivery System Reform Incentive Payment (DSRIP) program and the SIM-grant funded State Health Innovation Plan, which is convening a multi-stakeholder process through the State's Innovation Center to define and support Advanced Primary Care (APC). DSRIP is now in the third quarter of Year 2, where the 25 Performing Provider Systems (PPSs) from all over the state are transitioning from meeting project progress milestones to achieving outcome-based measures. APC, which aims to enable a shift toward value through transformation milestones, core measures, and a multi-payer framework for prospective payment conditional on achievement of milestones

<sup>1</sup> National Center for Health Statistics 2014

And performance on measures, is progressing toward implementation of practice transformation statewide in 2017. Regional governance structures that will manage APC roll-out across New York State and convene local stakeholders deeply committed to the success of APC within communities will initially kick-off in four regions in early 2017 (New York City, the Capital Region/Hudson Valley, the Adirondacks, and the Finger Lakes). Additional governance roll-out will follow subsequently, covering the rest of the state by 2019. The APC effort is supported by public and private payers including Medicaid, SIM-funded practice transformation technical support, common measurement, health information technology (HIT) infrastructure (All-Payer Database and Statewide Health Information Network for New York), and Regional Oversight and Management Committees (ROMCs). APC is envisioned as a first step toward facilitating multi-payer initiatives in all specialties.

Within the State, Medicaid is collaborating closely with the NYS Innovation Center to align APC, the DSRIP primary care strategy, and recent CMS descriptions of Advanced Alternative Payment Models (APMs). Medicaid is increasingly aligned with APC: APC practices will qualify as meeting PPS primary care requirements, and the Medicaid Value Based Payment (VBP) program has fully adopted the APC core measures. Levels 2 and 3 of the Value-Based Payment (VBP) roadmap would meet Advanced APM requirements as currently described, and efforts are underway to ensure that the APC program does so as well.

The participation and leadership of Medicare, as one of the largest payers in the state, is important to the success of these efforts. While dialogue is ongoing, a request from NYS Medicaid at the end of 2015 to allow reciprocal member participation in the Medicare CMMI models and Medicaid VBP models as a way of reconciling the programs for providers has not been approved. Progress in the dual-eligible population in particular, which has high morbidity and high healthcare utilization and is the ideal population to benefit from a value-based approach to healthcare, is still limited by obstacles to leveraging shared savings across the Medicaid-Medicare divide. The State continues to engage with private payers on APC, which is largely aligned with Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+), but has not yet secured the participation or leadership of Medicare.

Specific policy proposals include the following:

***Program alignment:***

- 1a. **NYS Medicaid and the NYS Innovation Center will closely partner in APC governance and roll-out, and articulate the vision of APC as a central part of the State's vision of primary care.** Programs such as NCQA Patient-Centered Medical Home (PCMH) incentives and Value Based Payment (VBP) currently align with APC principles, and the State will continue to refine coordination as part of the APC roll-out. *(RFI Section I, Question 1)*
- 1b. **The State will encourage the availability of VBP models for APC that meet the Quality Payment Program (QPP) criteria for Advanced APM recognition.** Providers not able to assume the risk criteria required for Advanced APM recognition will still be able to participate in APC. *(RFI Section I, Question 1)*

- 1c. **The State will work with NCQA to reconcile the APC milestones and the upcoming PCMH 2017 criteria**, as part of an effort to align allied programs and recognize progress that has already been enabled through Medicaid's financial support of NCQA PCMH certification. *(RFI Section I, Question 1)*
- 1d. **CMS and New York's Medicaid program should enter into a reciprocal arrangement to allow providers to reconcile their value-based programs with Medicaid and Medicare.** Specifically, providers should be able to enroll dual-eligible and Medicare fee-for-service (FFS) beneficiaries in applicable Medicaid-sponsored value-based programs. Medicaid already allows providers to enroll Medicaid beneficiaries in applicable Medicare value-based programs. These programs may include existing Medicare-approved models such as the Medicare Shared Savings Program (MSSP), Next-Gen ACO models, Bundled Payment models, or if adopted, an APC-compatible plan(s). A first step in this reciprocal arrangement can focus on the dual-eligible population. *(RFI Section I, Question 1)*

***Public payer influence:***

- 1e. **As part of the VBP Roadmap, NYS Medicaid will encourage Managed Care Organizations (MCOs) to offer VBP contracts that align with APC to all qualified NYS primary care providers.** NYS Medicaid will build on the alignment that already exists between MCOs and APC, such as the adoption of APC Core Measures. *(RFI Section I, Question 1)*
- 1f. **CMS should encourage the Medicare FFS plan and Medicare Advantage plans in the State to offer APC-compatible provider contracts.** As CMS looks to expand its reach in advancing primary care, priority should be given to regions of the state with an already existing critical mass of payers supporting APC. *(RFI Section I, Question 1)*
- 1g. **As Medicaid and Medicare encourage providers to take-up their own value-based payment models, both should promote multi-payer scale in VBP among providers across a broader proportion of their patient panels.** *(RFI Section I, Question 1)*
- 1h. **The State will work with New York's public employee plans to participate in APC**, including the New York State Health Insurance Program (NY-SHIP) and New York City's Office of Labor Relations (NYC-OLR). *(RFI Section I, Question 1)*

**2. Fundamental change requires consistent focus and support over time, not just a proliferation of innovation.**

**Policy proposals summary**

- **Program sustainability:** The State and CMS should provide a clear plan for program sustainability once currently planned funding mechanisms end.
- **Performance recognition:** The State and CMS should recognize and reward providers for sustaining high performance, as well as performance improvement.

New care delivery and payment models require practices to transform through investments across several areas that require focus and continuity over time:

- *New capabilities and infrastructure:* Adopting and developing new capabilities, workflows, and HIT;
- *Workforce development:* Recruiting and integrating new workers—such as care managers and care coordinators—as well as training existing practice personnel in new workflows;
- *Communication and engagement:* Communicating clear expectations and direction to stakeholders about the timeline of changes and implementation, and building structures for meaningful consumer engagement; and,
- *Integration:* Building relationships and coordinating care across providers, community-based organizations, and social services organizations to improve population health management.

To complement healthcare delivery improvements, sustained investments in population health, community-based organizations, and consumer engagement are needed. Improving New York's health outcomes requires addressing social and physical conditions outside the healthcare system, such as access to healthy foods, safe neighborhoods, stable housing, transportation, and educational, economic, and employment opportunities. Moreover, new healthcare models encouraging use of public and community-based resources and empowering consumers to take a more active role in their health create additional capacity demands and a greater need for consumer education and engagement. The State is committed to its ongoing work with community-based organizations and social and public health organizations as part of its SHIP plan and DSRIP initiatives and sees this engagement as a priority in the long term.

Currently, many CMMI programs are planned as time-delimited, short-term programs. While the State recognizes these programs are meant to be trials of innovative approaches, without a specific plan for what is to follow at the conclusion of these programs the progress enabled by significant investments from providers, payers, and CMS is put at risk.



The State has had the privilege of collaborating with CMS and CMMI on several pioneering programs and understands the need to have a clear plan for continuity for the programs to succeed. CMMI's Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration in the rural Adirondacks region of New York, for example, spurred significant growth in primary care practice capabilities and spurred formation of practice "pods" to enable independent practices to achieve the scale necessary to provide advanced, patient-centered primary care. The program, which involved investments from payers and providers alike to enable change, has shown a positive trend in cost and quality data. With the five-year demonstration set to end at the end of 2016, however, private payers and providers have seen sufficient value to continue the multi-payer initiative, though Medicare is now the only payer not participating in the ongoing program. Meanwhile, several new CMS-driven programs, such as Transforming Clinical Practices Initiative (TCPI) and CPC+, are being rolled out in the State.<sup>2</sup>

In order to improve care delivery, we need to recalibrate the balance of executing against a common framework, versus allowing an ongoing array of new and different models, each with varying programmatic, technical, measurement, and timeline requirements.

Even when existing models succeed in improving healthcare performance, maintaining high levels of performance requires sustained effort on the part of providers. Current incentives remain primarily focused on providers meeting ever-increasing benchmarks and targets as they progress through transformation. Without incentives that support ongoing investment, many providers may not sustain high performance.

Specific policy proposals include the following:

■ **Program sustainability:**

- 2a. **CMS should establish a clear post-program transition plan for current CMMI programs operating in the State rather than introducing new models.** In a setting where there are already several models that providers are adopting, CMS should focus on refining and adapting existing models. With many of these programs still in the early stages of implementation and cross-program alignment, the introduction of new models could discourage providers from making the investments necessary to successfully change in current ongoing programs. *(RFI Section I, Question 1; Section II, Question 2)*
- 2b. **The State will establish a clear post-program transition plan for State-run programs.** The State will work with payers including CMS and providers to ensure sustained impact in programs such as DSRIP, APC, and other incentives for enhanced primary care practice once current funding mechanisms are phased out. Medicaid's VBP roadmap is an example of the State's long-term focus on sustainability. *(RFI Section I, Question 1)*

■ **Performance recognition:**

<sup>2</sup> The following models have been or will be implemented in the State of New York: Bundled Payments for Care Improvement (BPCI) initiative, CPC, CPC+, MAPCP, Pioneer ACO Model, TCPI

- 2c. **The State and CMS should work to recognize providers for sustained high performance, as well as performance improvements.** Both public entities should set a standard that other payers can follow, as part of a consultative process. Medicaid's VBP roadmap has integrated many lessons learned by CMMI as well as commercial VBP programs to adequately reward both efficiency and quality performance as well as improvement, and will continue to refine this approach. *(RFI Section I, Question 1)*



### **3. Transformation requires actionable insights driven by data that is comprehensive, transparent, and relevant.**

#### **Policy proposals summary**

- **Data completeness:** Medicare should fully join private payers and Medicaid in the All-Payer Database (APD) and in multi-payer data reporting efforts like the Advanced Primary Care Core Measures.
- **Data use:** Both Medicare and NYS Medicaid should lead a multi-payer coalition encouraging the use of SHIN-NY and APD resources through provider incentives such as those in the Advanced Primary Care program and the VBP roadmap, as well as in future multi-payer alternative payment models.
- **Ongoing refinement and evolution:** Measures of health and healthcare delivery should be created and refined through a collaborative process between Medicare, states, and other stakeholders across the care continuum.

The ability to generate and exchange insights from clinical, claims-based, and other data is an important enabler of the effectiveness and efficiency of healthcare delivery. This applies to care management, population health management, performance measurement, and transparency efforts to drive smart decision-making by providers, patients, consumers, and other stakeholders. Data-driven insights help to close care gaps, reduce mistakes and duplication, improve care coordination, and identify sources of value that are meaningful to both providers and consumers.

In the State and across the country, healthcare data has largely been held in siloes and insufficiently shared. Payers each generate multiple differing reports, based on claims generated from small sub-sections of provider patient panels, which are tied to varying performance-based payments. Providers, in turn, use a wide range of tools to collect data, from paper charts to electronic health records, and often share data through limited faxes of reports. Finally, consumers have difficulty accessing, understanding, and using their own health data as well as payer and provider performance data.

The State is working on several systems to support the use of healthcare data. Two of the most prominent are the State Health Information Network of New York (SHIN-NY), which facilitates exchange of provider-held electronic clinical information, and the in-progress All-Payer Database, which will begin with multi-payer claims and expand to include provider clinical data and public health data. Leveraging these systems, and in an effort to support NYS OHIP's DSRIP goals, the State has made detailed data on preventable hospitalizations (for both all patients and for Medicaid patients specifically), chronic conditions, and readmissions among Medicaid recipients available publicly.

Future plans include the creation of all-payer primary care and specialty report cards at various levels of granularity, from single outpatient practices to regions and statewide. A first step will be the creation of APC scorecards, to be aligned with roll-

out of the APC program. More broadly, the State continues to work to increase transparency on critical health data including costs, and to improve consumer engagement with their data. Data collection, exchange, and analysis enabled by these systems have the potential to change how care is coordinated and delivered, better measure performance over more meaningful sections of patients, and allow for in-depth research.

An important complement to creating the data infrastructure is ensuring that it is applied in practice. NYS Medicaid's DSRIP introduces payments for reporting in early years, ties payments to performance on metrics starting in years 2 and 3 of the waiver, and also requires providers to connect to a Regional Health Information Organization (RHIO), which is part of the SHIN-NY infrastructure. The Medicaid VBP program ties additional outcome measures including efficiency measures to both MCO and VBP contractor payments. These efforts enable an unprecedented level of transparency in both efficiency and quality delivered by MCOs, as well as VBP Contractors. APC aims to effect similar change among a critical mass of public and private payers, both tying payment to a targeted and standardized set of measures, and also requiring connection and interaction with RHIOs.

Despite this progress, however, a great deal remains to be done, both within the State and on the part of CMS. Complete data are not yet available in the APD (for example, the APD has data agreements for the dual-eligible FFS population, but does not yet have data agreements with the rest of Medicare FFS, or with Medicare Advantage plans), and current use of new resources is still far from fulfilling their potential (for example, while the rate of EHR connection to SHIN-NY in hospitals and long-term facilities is above 90%, outpatient clinical practices are currently at 22% statewide). Furthermore, alignment on core measure sets within the State is an ongoing process, needing ongoing reconciliation with new national initiatives such as the Core Quality Measures Collaborative's core measures in primary care and other settings.

Specific policy proposals include the following:

■ **Data completeness:**

- 3a. **The State will continue its commitment to increase the role and completeness of the APD and SHIN-NY** in collaboration with payers (including Medicaid), providers, and other sources across the care continuum. These resources over the longer term are envisioned as a home for cross-agency data integration, including claims, clinical, public health, and other public data. *(RFI Section I, Question 3)*
- 3b. **CMS should ensure timely availability of Medicare FFS and Medicare Advantage data within the State APD.** Of particular priority is ensuring data completeness in service of the APC Core Measures. *(RFI Section I, Question 3)*

■ **Data use:**

- 3c. **The State will continue to support the adoption of the APC Core Measures and SHIN-NY, as well as a multi-payer effort to use the Core**

**Measures for payment as part of APC.** Through implementation of DSRIP's primary care plans including APC and PCMH, Medicaid will encourage providers to engage with data and with SHIN-NY, and APC milestones will engage other payers and providers in the same vein. These efforts will facilitate the exchange of data insights, measure performance, and enable coordination of care and resources. Future evolutions of the APC scorecard concept may be adapted for specialists and for facility-based providers across the care continuum. *(RFI Section I, Question 3)*

- 3d. **The State will commit to using the SHIN-NY and APD infrastructure to advance transparency** among providers, between providers and payers, and for patients and consumers more broadly. Empowering consumers to make choices based on value, as well as better engaging consumers in their own health, will be ongoing priorities. Part of this effort will be to develop a statewide and regional population health scorecard, using data from private payers, public payers including Medicare and Medicaid, and providers, as well as from state and local agencies (e.g., public health, housing, education). The State will work with relevant stakeholders including payers, providers, and community organizations to ensure that data are accessible, relevant, and interpretable by intended audiences. *(RFI Section I, Questions 2 and 3)*
- 3e. **Medicaid will be a leader among NYS payers in using the APC Core Measures in its primary care transformation programs.** Depending on the specific program (e.g., a particular bundle), there may be additional measures in addition to the APC Core Measures, especially as some programs may address specific populations such as women, children, or members with significant behavioral health issues. For future State-led multi-payer initiatives involving core measures in other settings of care, NYS Medicaid will endeavor to collaborate as a partner in both their development and implementation. *(RFI Section I, Question 3)*
- 3f. **CMS should actively support the use of SHIN-NY, the APC core measure set, and Medicaid DSRIP and VBP measures** through its participation in NY multi-payer programs (e.g., within the CPC+ and APC frameworks, as well as other APMs) and its collaboration with NY DSRIP, as detailed above. *(RFI Section I, Question 3)*

■ **Ongoing refinement and evolution:**

- 3g. **CMS and the State should collaboratively review existing measures and develop new measures that impact the State.** CMS should consult with New York and other states, particularly those developing advanced capabilities with the support of SIM grants, before rolling out new measures on a national level. For future state-led multi-payer initiatives concerning Core Measures, including initiatives with focus beyond primary care, the State and CMS should collaborate as partners in both the development and implementation of the new core measure sets in New York. *(RFI Section I, Question 3)*
- 3h. **The State seeks collaboration with CMS and other non-governmental stakeholders in better defining measures of social determinants of health, as well as their optimal application.** Social determinants of health

are a particular area where new measures must be clearly defined, and where the best application of data is yet to be determined. (*Section II, Question 4*)

4. **The public sector at both the State and Federal levels should take an active leadership role, and commit to a step-change improvement in alignment and collaboration.**

#### **Policy proposals summary**

- **A stronger partnership between New York and CMS: The State will take a proactive role in coordinating all multi-payer healthcare reform efforts within New York through a stronger partnership with CMS, wherein the State and CMS collaboratively identify and address healthcare innovation issues within New York.**
- **Breaking down CMS siloes: CMS should continue to improve coordination within its departments and reconcile differences between its multiple programs to ensure a consistent strategy and message.**

CMML's push to drive healthcare innovation through the SIM program combines the strengths of both federal and state-level leadership. CMS brings nationwide scale and leverage as a national payer, as well as the ability to evaluate performance across multiple states and share best practices. States, in turn, are well positioned to drive innovative healthcare models for several reasons: their geographic scale enables them to tailor complex innovation approaches through multi-stakeholder policy and programmatic discussions; they are the largest local purchasers of health insurance through Medicaid and public employees plans (e.g., NY-SHIP); they are the primary regulator of both private payers and providers; and they are the primary home for HIT infrastructure like the APD and SHIN-NY.

In the setting of a long-standing and productive collaboration with CMS and CMML, New York's experience to date suggests opportunities for improvement in communication and coordination. Lines of communication between the State and CMS/CMML can be strengthened to better enable the State and other stakeholders to effectively understand, design, troubleshoot, and coordinate the implementation of simultaneous CMS/CMML models. Coordination between various state and federal-led programs (e.g., DSRIP, SIM, CPC+, TCPI, MAPCP, MIPS/MACRA, HARP) has been a challenge for the State as well as providers, consumers, and commercial payers within New York. Furthermore, policy differences among federal regulations may at times be at odds with shared goals, for example, achieving full behavioral health integration with primary care in FQHCs and hospital extension clinics. The complexity of programs – even if the programs are innovative – threatens to undermine good intentions, as it has generated confusion, required significant work and time for program reconciliation, and distracted focus from the core task of healthcare transformation.

The State needs an improved engagement model that still allows CMS to be a leader in setting national goals, measuring success and disseminating best practices, but that actively empowers states and local stakeholders to drive solutions that work for their populations.

Specific policy proposals include the following:

■ ***A stronger partnership between New York and CMS:***

- 4a. **The State will increase its role as a convener and programmatic and policy partner for all multi-payer value-based payment and transformation programs** (including APC, CPC+, TCPI, DSRIP, MACRA, and future efforts) in coordination with local stakeholders. The State will also take the lead in integrating healthcare transformation with allied efforts, including population health and social services. In regions, APC governance structures can serve as a forum for dialogue among stakeholders, troubleshoot operational issues, and identify critical issues for resolution by the State. CMS support is essential to the success of this effort, and should include ingraining the State's expanded role within its new programs in New York, and helping support necessary resources to carry out that role. *(RFI Section I, Question 1)*
- 4b. **CMS/CMMI should evolve its operating and oversight model to better enable state adaptation of innovation and transformation programs**, while continuing to adhere to a common set of principles and performance expectations, and facilitating participation of CMS as a payer in that state. In New York, CMS should closely partner with the State to identify and resolve state-specific issues through an ongoing bi-directional consultative process with the authority to enable necessary changes. An important early step is better coordinating value-based incentives across all settings of care for the Medicare and Medicaid dual-eligible population. *(RFI Section III, Question 1)*
- 4c. **CMS/CMMI should strengthen the role of Program Officers, in order to improve efficient access to information and facilitation of solutions.** Specifically, Program Officers should be able to both facilitate direct communication between the State and any given CMS department or CMS-sponsored program being implemented in New York State, and also proactively flag and collaboratively develop solutions to issues that may have cross-state relevance. *(RFI Section III, Questions 1 and 2)*

■ ***Breaking down CMS siloes:***

- 4d. **CMS should continue to facilitate coordination and communication between its departments** as part of an understanding that the various CMS programs affect the same set of markets and stakeholders. *(RFI Section III, Question 2)*
- 4e. **CMS should bolster efforts to reconcile programmatic and/or technical differences among its current CMS and CMMI programs**, including SIM, CPC+, TCPI, MAPCP, DSRIP, and others, with input from states. Important areas of reconciliation include measures of quality and utilization as well as care models and timelines for transformation. Reconciliation should also include amending regulations so that providers such as hospital extension clinics and FQHCs may also participate in behavioral health innovation models. *(RFI Section III, Question 2)*

## C. CONCLUSION

New York is moving fast against the timelines of multiple transformation programs operating in the State. APC-compatible contracts will be available in the early part of 2017. CPC+ will launch in January 2017 in the North Hudson-Capital Region. The PPSs will continue to work with their network partners to develop a plan towards meeting the DSRIP VBP goal as outline in the VBP Roadmap. The State aims to tightly pair those efforts with efforts to develop population health and community-based resources and engage with consumers, as stated in the New York SHIP plan.

This response has put forth many new policy proposals to make payment and delivery reform successful in the State. Achieving actionable definition, clarity, and alignment on programmatic, technical, and operational details will require additional work and collaboration from multiple stakeholders. The focus here has been to provide an overview of what the State believes is required to increase the overall effectiveness of federal, state, and private sector primary care transformation efforts statewide.

We look forward to continued collaboration with CMS to achieve better health, quality of care, and healthcare affordability in the State of New York.





October 28, 2016

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**RE: Request for Information: Input on Potential State-Based Payment and Delivery System Reform Initiatives**

Dear Dr. Conway:

The National Association Action Alliance for Suicide Prevention (Action Alliance) is the public-private partnership advancing the National Strategy for Suicide Prevention and championing suicide as a national priority. The Action Alliance has prioritized transforming health systems to reduce suicide as is engaged in a number of efforts nationally to fundamentally transform the delivery of suicide care and make health care suicide safe.

State-based payment and delivery system reform initiatives are essential as we know people are dying from suicide that are under the care of health systems. We also know that our nation's state behavioral health systems are not suicide safe. Recent data indicates that in Ohio, from 2007-2011, 20.2% of people who died from suicide were seen in the public behavioral health system within 2 years of death. We also know that in New York, in 2012 there were 226 suicide deaths among consumers of public mental health services, accounting for 13% of all suicide deaths in the state. In Vermont, in 2013, 20.4% of the people who died from suicide had at least one service from state-funded mental health or substance abuse treatment agencies within 1 year of death. We must do more to ensure our health systems are suicide safe and state-based payment and delivery system reform initiatives are a key component of that effort.

The Action Alliance requests that future payment and delivery system reform initiatives be crafted to better incorporate and integrate behavioral health services and outcome measures—particularly measures designed to help detect suicidal ideation and prevent suicides—than have previous and ongoing reform initiatives.

While the medical home initiative seems to have had produced some successful integration outcomes in the behavioral health field, largely because it was conceived in statute as a means to incorporate and integrate behavioral health (mental health and substance abuse disorder treatment and prevention) into a holistic health care model, the accountable care organization (ACO) approach has never been designed to encourage participation by behavioral health care providers. If fact, as originally designed, it failed to accommodate behavioral health services or providers who were not physicians or hospitals.

**The National Action Alliance for Suicide Prevention is the public-private partnership working to advance the National Strategy for Suicide Prevention and make suicide prevention a national priority. Education Development Center, Inc. operates the Secretariat for the Action Alliance through the Suicide Prevention Resource Center.**



The original design of the Medicare Shared Savings Program (MSSP), failed to accommodate behavioral health providers, either as lead entities in forming ACOs or as participants in ACO networks. The opportunity for behavioral health providers to become part of the ACO structure grew marginally with adoption of the final version of the regulations governing the Medicare Shared Savings Program (MSSP), but participation was still to be restricted by the attribution of patient outcomes to the patients' primary care providers and a continued limitation on which behavioral health providers could participate.

The incorporation and integration of behavioral health into the ACO model began to grow in design and popularity after CMS introduced the concept of the "Integrated Care Model" in a pair of 2012 State Medicaid Director letters. By July 2016, nine state Medicaid programs had active ACO elements or pilots, and a tenth state had submitted a proposal to modify and extend an existing § 1115 (statewide) Medicaid waiver using three separate ACO models. Seven more states were in the process of setting up their own Medicaid ACO programs

However, the promise that the ACO model could serve as a means of integrating behavioral and medical services in both the Medicare and Medicaid programs has not been achieved. Although researchers have found significant interest in integrating behavioral health providers into the ACO model, challenges have been posed by behavioral health workforce shortages and the slow adoption of costly health information technology by behavioral health providers lacking access to the Medicaid and Medicare meaningful use provider incentives available to other types of providers. Even within ACOs striving toward achieving integration, levels of integration vary among sites.

In addition, even where behavioral health providers do participate in some form of integrated care model, behavioral health measures are seldom used in measuring outcomes or determining shared savings.

Research indicates that the immediate period after discharge from acute care settings is when suicide death is most likely to occur. For both EDs and inpatient discharges, the risk for suicide attempts and death among all age groups is highest immediately after discharge and over the next 12 months to four years.<sup>12</sup> We also know that as many as 70% of suicide attempters of all ages never make it to their first appointment or fail to attend more than a few treatment sessions after discharge from an ED or from inpatient psychiatry<sup>3</sup>. Payment models that focus on preventing re-hospitalizations should include re-hospitalizations for behavioral health conditions and suicidal behavior. Preventing re-hospitalizations by improving care transitions and linkages to adequate outpatient care is critical for patients at very high risk for future suicidal behavior.

The Action Alliance (and partners) make several recommendations for integrating behavioral health services into ACOs as part of Medicaid payment and delivery system reforms:

- CMS and states should require that ACO leaders incorporate behavioral health providers in their governing bodies and networks, and should include attribution of enrollees to behavioral health providers.
- CMS and states should ensure that behavioral health quality outcomes and processes are measured and reported in ACO initiatives or any other payment and delivery system reform initiative, and that at least some portion of provider reimbursement is contingent on enrollee improvements on those outcomes. One seemingly obvious behavioral health process measure for incorporation in hospital measures that has been neglected is the reporting of emergency room physicians and other providers of patients admitted to the ED with suicidal<sup>1</sup>

<sup>1</sup> Goldacre M, et al, Lancet. 1993;342:283–286.

<sup>2</sup> Skeem JL, et al Behav Sci Law. 2006;24(6):731–746

<sup>3</sup> Boyer CA, et al. Am J Psychiatry. Oct 2000;157(10):1592-1598.

ideation and/or evidence of suicidal self-harm. A recent review of two statewide surveillance systems found that 10.7% of decedents who died by suicide were seen in a state ED within 6 weeks prior to death. In addition, ED attendees who died by suicide were more likely to have a diagnosis of injury/ poisoning diagnosis or mental disorder and more likely to have Medicare<sup>4</sup>.

As noted in the 2005 study [Suicide Assessment in Hospital Emergency Departments: Implications for Patient Satisfaction and Compliance](#).<sup>5</sup>

*The immediate focus of the assessment should be on the safety of the patient and the level of observation necessary to maintain their safety. Their general medical condition [can] also be assessed to determine if they need medical attention in addition to psychiatric assessment and treatment. Some risk factors that may lead the practitioner to believe it is unsafe for a patient to be alone include feelings of hopelessness, a definite suicide plan, a recent suicide attempt, severe depression, psychotic symptoms, a recent discharge from a psychiatric unit, the use of alcohol and/or street drugs, homelessness, or medical illness.*

...

*Proper assessment and diagnosis of suicide risk and potential can help save the lives of many individuals that are involved in crisis situations. Because patients in crisis often present to the emergency department for treatment, it is an ideal place to perform the initial suicide risk assessment of all crisis patients seeking assistance.*

A measure of the emergency room physician's or crisis stabilization provider's performance of a suicide risk assessment where there is evidence of patient self-harm should be essential to any future payment and delivery system reform initiative.

- Behavioral health providers have not been eligible for Medicaid and Medicare meaningful use incentives, and so have not had available the financial resources to adopt health information technology that hospitals and other health providers have had made available. CMS and states should be prepared to offer behavioral health providers incentives—financial and otherwise—for the adoption of health information technology to help facilitate the exchange of patient data between behavioral health providers, primary care and other medical/surgical providers, and the state.
- In order to facilitate enrollee participation and enrollee self-reporting and provider reporting of outcomes, CMS should ensure that states educate both enrollees and providers on how to best handle behavioral health societal stigma. Education on permissible disclosures under 42 CFR Part 2 restrictions should also be included in any educational and training module provided for participating providers, enrollees, and health information exchanges.
- CMS and states should preempt inevitable behavioral health workforce shortages by considering the inclusion of non-physician behavioral health providers in the ACO network and the use of tele-behavioral health to supplement in-person treatment.
- CMS should ensure that behavioral health provider reimbursement is adequate to ensure that behavioral health providers are as accessible within the Medicaid ACO as they are in the general medical community. If a shared savings approach is to be used, the state may want to consider supplementing that approach through outcomes-based incentive payments sufficient to ensure that providers are not discouraged by low reimbursement from continued participation in the ACO initiative.
- CMS should ensure ACO- initiatives integrating and incorporating behavioral health be given time to develop in order to produce sustainable positive patient outcomes and provider revenues through shared savings or incentive payments significant enough for providers to want to participate.
- CMS and states should consider the use of an incentive program to reduce the re-hospitalization rate and improve health outcomes that specifically includes individuals hospitalized for behavioral health conditions including suicidal behavior.

<sup>4</sup> Cerel, J., et al. Crisis: The Journal of Crisis Intervention and Suicide Prevention, Vol 37(1), 2016, 5-12.

<sup>5</sup> Mitchell, A.M. et al, Top Emerg Med. 2005 Oct; 27(4): 302–312.

In response to CMS's request for additional information related to implementing financial accountability for health outcomes for an entire state's population- we strongly encourage CMS and state systems to incentivize states to improve the timeliness of reporting state-level mortality data so that state-level policy makers are able to tie incentives to reported health outcomes in a timely manner. The delay in the state-level reporting of this data creates a barrier as it prevents payers and health systems from being able to accurately and timely track (by matching health records and state death records) poor health outcomes and deaths related to suicide- the ultimate poor health outcome for someone who has been engaged with the health system.

Improving health system's capacity and accountability for preventing suicide for patients under their care is critical. The highest risk group for suicide is those who have previously attempted suicide. Among that diverse group, we know risk is further stratified. Recent analysis indicates that among adult suicide attempters in the U.S. aged 45 or older, the overall 12-month suicide case fatality rate was 7.6% for men (highest at 7.9% for non-Hispanic white men) and higher among those with less than high school education (16%) <sup>6</sup>. Our health systems can do better and state innovation models where there is accountability for behavioral health related outcomes and incentives to improve care are key to supporting health system efforts to assess, treat, and manage suicide risk among their patients.

Please feel free to contact me with any questions or comments at [ccarr@edc.org](mailto:ccarr@edc.org).

With sincere appreciation for your consideration of these matters,

Colleen Carr  
Manager of Policy and Strategic Partnerships  
National Action Alliance for Suicide Prevention, Executive Secretariat  
EDC

<sup>6</sup>Han et al., Journal of Psychiatric Research 77 (2016) 125-133.



UnityPoint Health

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October 28, 2016

Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services

RE: Request for Information on State Innovation Model Concepts

*Submitted electronically via [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)*

Dear Mr. Slavitt:

UnityPoint Health (UPH) is pleased to provide input in response to the Centers for Medicare & Medicaid Services' (CMS) request for information on the State Innovation Model. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin. Through our affiliated ACO, UPH has partnered with CMS from the inception of Medicare ACO programming. Trinity Pioneer ACO, representing a rural eight-county service area in central northwest Iowa, started in the CMMI Pioneer Model ACO program in 2012. The Trinity Pioneer ACO achieved two years of savings through program innovation and coordination. In July 2012, UnityPoint Health Partners, representing the majority of our remaining service area regions, began its participation in the MSSP ACO model. Since January 2016, we combined our Medicare ACO efforts under UnityPoint Health Partners to participate in the first cohort of the Next Generation ACO (NGACO). Our NGACO providers care for more than 73,000 NGACO beneficiaries, and we are the largest ACO in the NGACO program.

As an integrated healthcare system and a NGACO, UPH believes that patient-centered care is best supported by a value-based payment structure that enables healthcare providers to focus on population health instead of volume-based episodic care. We appreciate this effort by CMS to seek stakeholder input in how to best develop the SIM in support of multipayer payment models. We respectfully offer the following provider perspective.

**[MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS](#)**

UPH highly supports multi-payer strategies in which **states align with existing Medicare models**, instead of encouraging state-specific new payer models. As a large integrated health system with providers and facilities in three states, this national approach promotes alignment of healthcare delivery priorities, common minimum quality standards, and regulatory consistency. For providers serving in communities on state borders, this larger focus will assist them to concentrate on patient care holistically rather than meeting multiple and competing state-driven healthcare goals related to value-based arrangements.

### **Value-Based Payment Models**

As the largest NGACO within the first cohort, UPH would be thrilled to have the opportunity to engage in multipayer initiatives that support present Advanced APM models and encourage sustainable delivery and payment reforms. We advocate for a Value Based Payment (VBP) system that is designed in a manner that aligns with the structure and goals of CMS on VBP and enhances the ability of providers to meet the requirements of the MACRA payment terms. We encourage greater input by providers in the SIM. Our concern lies with embedding too much flexibility in SIM to States and their commercial health plan partners, which effectively establish through regulation siloed standards of care delivery. We recommend that CMS establish basic constructs for SIM grantees that encourage holistic care and streamlined regulations and incent participation by providers in risk-based VBP programs. UPH recommends that the SIM be reconfigured to include the following:

#### ***1. Different Types of VBP Options***

While providers assuming risk is a fundamental part of VBP, providers are at different levels of maturity in regard to capabilities and networks. SIM grantees, including Managed Care Organization (MCO) subcontractors, and VBP contractors (i.e. providers) should be able to select different levels of defined VBP arrangements. Types of VBP arrangements supported by SIM funds should include, at a minimum:

##### **(a) Total cost of care for the general population**

In this model, the State Medicaid agency (or its MCOs) enters into a VBP arrangement with the Provider (ACO or Group) which considers total PMPM (per member per month) expenditure for the total attributed population (Global Capitation), and overall outcomes of care (potentially avoidable ED visits, hospital admissions, and the underlying VBP quality metrics). There are significant opportunities to reduce costs and improve quality by expanding total cost of care contracting. This model would be a good avenue for many providers to meet MACRA risk-bearing requirements.

##### **(b) Bundles of care**

In this model, the State Medicaid agency (or its MCOs) contracts for specific, patient-focused bundles of care (such as maternity care episodes or stroke). Here, the cost of a patient's office visits, tests, treatments and hospitalizations associated with a specific illness, medical event, or condition are all rolled or "bundled" into a single, episode-based total cost for the episode. Because variations in utilization and potentially avoidable complications are linked to the specific episodes, this model has shown much promise in stimulating patient-focused, integrated care delivery teams to substantially increase the value of care delivered from a wide range of conditions. This model is a good avenue for specialists to become engaged in Medicaid VBP.

contracting and can assist physicians in qualifying for bonus payments under MACRA, if designed in alignment with Medicare.

**(c) Total care for special needs subpopulations**

For some specific subpopulations, severe co-morbidity or disability may require highly specific and costly care needs, so that the majority (or even all) of the care costs are included in the full- year-of-care bundles.

**2. Differing Levels of Risk Providers Could Assume to Qualify as a VBP**

Providers are at different places in regard to the amount of financial risk they are ready or able to take in regard to the Medicaid population. To be an Advanced APM, CMS requires nominal risk-bearing arrangements, which are not reflected in our current SIM supported contracts. Therefore, the SIM should accommodate differing levels of risk that include, at minimum, the following:

**(a) Level 0 FFS with bonus**

FFS with bonus and/or withhold based on quality scores is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment. Such payment does not align with Medicare's risk bearing requirements. Some States continue to reimburse preventative services on a FFS basis because it is positive to incent volume in such areas.

**(b) Level 1 FFS with upside-only**

Under this model, shared savings are achieved when quality outcome scores are sufficient. This Level consists of 'upside only' shared savings arrangements. Here, the capitation and bundled payments exist only virtually. When the accrued fee-for-service payments for the integrated care service are lower than the virtual PMPM capitation or bundle budget, the MCO can share the savings with the parties in the contract ('retrospective reconciliation'). Potential provider losses are not shared and providers are not 'at risk'.

**(c) Level 2 FFS with risk sharing, upside and downside risk**

Under this model, shared savings are available when total cost of care is under the benchmark and quality outcome scores are sufficient and downside risk is reduced when total cost of care is over the benchmark and quality outcome scores are high.

**(d) Level 3 Global capitation (with outcome-based component)**

Capitation arrangements for all or portions of populations with a quality component would consist of 'upside and downside' risk-sharing arrangements. To reduce unwarranted insurance risk for providers, stop loss, risk corridors and/or other risk-mitigation strategies could be authorized.

**3. Innovator Program for Providers Ready to Assume More Risk**




























A voluntary Innovator Program, similar to that created in New York,<sup>1</sup> should be an option for VBP Providers/ACOs prepared for participation in Level 2 and 3 value-based arrangements by Year 2019. In the State of New York, General Population and Subpopulation value-based arrangements are rewarded by receiving up to 95% of the total dollars which have been traditionally paid from the State to MCOs. The




<sup>1</sup> See *New Roadmap, Annual Update, June 2016, Appendix IX, page 84*



Innovator Program is intended to encourage and reward early adoption of VBP arrangements, supporting those groups who have made investments in moving towards population health management.

Specifically, the Innovator Program rewards providers with up to 95% of premium pass-through for total risk arrangements as the prime Program benefit. The pass-through percentage is determined by analyzing the amount of the risk and administrative tasks taken on by the providers: more delegation results in higher percentage of premium (between 90% and 95%). The providers are required to pass a strict set of criteria to be deemed an ‘innovator’ and once they have reached Innovator status, all MCOs are required to participate in these arrangements. We would recommend that the specifics of an Innovator Program should be outlined in the VBP contract. Administrative functions that can be fully or partially delegated, as well as those that cannot be delegated, are displayed below.<sup>2</sup>

Optimum			
#	MCO Administrative Functions*	MCO	Provider
1	Utilization Review (UR)		
2	Utilization and Care Management (UM)		
3	Drug Utilization Reviews (DUR)		
4	Appeals and Grievances		
5	Quality		
6	Claims Administration		
7	Member/Customer Service		
8	Network Management		
9	Risk Adjustment & Reinsurance		
10	Disease Management		
11	Provider Services Helpdesk		
12	Provider Relations		
13	Credentialing		
14	Data Sharing		
15	Member Enrollment/Advertising		
16	Fraud, Waste and Abuse		
17	Legal		
18	Compliance		

Legend	
	Sole Responsibility
	Shared Responsibility
	Can't be delegated

In the New York model, to be eligible for 90% premium pass-through, functions 1, 2 and 10, listed in the table above, must be fully delegated to the provider, while at least half of the tasks listed as “shared” should be partially delegated. To be eligible for the 95% premium, tasks 1, 2, 6, 10 and 13 must be fully

<sup>2</sup> Id.

Delegated to the provider, while all the other tasks should be delegated to the maximum amount possible. Percentages may be set between 90 and 95% depending on the exact delegation of tasks negotiated.

#### ***4. A Medicaid Quality Program That Aligns With and Qualifies for Medicare Programming***

UPH has participated in value-based contracts with Medicare, Medicaid and commercial payers. Through various contracts, UPH collects, monitors and reports on over 200 quality measures. Streamlining quality measures and reporting requirements across multiple payers would reduce administrative burdens on providers and allow efforts to more appropriately focus on patient care.

Beginning in 2019, MACRA allows an All-Payer Threshold Option to achieve a Qualified Provider status under an Advanced APM. We encourage CMS to require that SIM grantees utilize quality measures that comport with the quality framework set forth in the CMS Quality Measure Development Plan (MDP) in support of MACRA. Of note, within the MDP, Advanced APMS are provided considerable deference so that Advanced APM reporting remains focused on innovative programming and Merit-based Incentive Payment System (MIPS) reporting requirements should align but not increase Advanced APM reporting domain requirements. In support of MACRA, we would suggest that SIM grantees not only follow MACRA quality guidelines but provide similar reporting deference to Advanced APMS participating in SIM projects.

We also discourage SIM grantees from developing/adopting their own VBP quality reporting constructs without consideration to, and preference for, Medicare quality measures, when applicable. In particular, if a State Medicaid agency, or their contractors, choose to measure a condition or outcome within a current Medicare program, they should use the same measure – for instance, the Medicare ACO quality measures should be used by Medicaid for similar conditions or outcomes (understanding that age parameters for Medicaid may need to be adjusted). We are concerned that the SIM project in Iowa has chosen to adopt a VBP composite measurement tool (i.e. Value Index Score developed by 3M) that was developed for one health plan in Iowa based on a commercial population. Providers have raised numerous concerns related to this tool.<sup>3</sup> The SIM project gives undue legitimacy to this tool. Its fit with the MDP

<sup>3</sup> Concerns identified by a cross selection of UPC physicians and UPHACO directors as of 9/16 include:

(i) Measurement Selection – We question the use of some of the underlying VIS measures.

(ii) Measures Are Divergent from Similar Evidence-Based ACO Measures - We have established workflows to address NQF metrics outside the VIS.

(iii) Measurement Selection Lacked Meaningful Provider Input – While 3M offers that the VIS tool is based on a tremendous amount of actuarial work, we do not know the extent to which Iowa providers were engaged in this development process. Wellmark Blue Cross Blue Shield cites to provider focus groups and IME references the SIM planning process to show provider engagement in tool development. We are unaware of any significant changes that have been incorporated into the measures themselves as a result of these efforts.

(iv) Non-Transparent Scores and “Black Box” Calculations - These scores cannot be replicated by providers. While 3M provides a list (The 3M<sup>SM</sup> Value Index Score (VIS): Measurement and Evidence (March 2015) of measures identifying denominators and numerators, it is unclear how all measures are weighted in their respective quality domains. Of particular concern are the efficiency and tertiary prevention domains, in which not only the weighting is known but the underlying measures are confusing.



deserves scrutiny as it related to quality domains and underlying measures, which do not fit evidence- based parameters in MDP. More importantly, it is questionable whether this tool is adequate for use with the Medicaid Population. The VIS tool was developed for a commercial population, which is generally healthier and exhibit fewer social determinants of health than Medicaid population. We are unaware of any other Medicaid program which utilizes the VIS tool. Among populations lacking adequate measures are the pediatric population (given the percentage of Iowa children covered by Medicaid) as well as patients presenting with behavioral health diagnoses.

#### ***5. A VBP Steering Committee and Clinical Advisory Group***

The goals of the SIM Grant, as well as programming within many States and their respective Medicaid agencies, are to improve population health and individual health outcomes and to reward high value care delivery. These goals will not be obtained without reforming the Medicaid payment system. The selection of the VBP arrangements and the selection of accompanying quality measures need to be closely aligned. A new payment system cannot be designed without involving the healthcare delivery systems that care for the Medicaid beneficiaries. It has been our experience that healthcare delivery systems have limited or no representation on meaningful SIM steering committees, particularly in decision making bodies surrounding VBP.

We propose that the SIM require the creation of a Value Based Steering Committee to establish and monitor VBP options, risk levels, and innovation efforts. At a minimum, providers with experience in risk based VBPs should be on the Steering Committee. Further, CMS should require the establishment of a Clinical Advisory Group (CAG) to validate proposed bundle or subpopulation definition and corresponding analysis, and decide upon a set of quality measures for each arrangement. Members to the CAG should be nominated through recommendations from VBP Steering Committee members, other State agencies, professional groups and associations. Specific consideration should be given to the composition of the CAG to ensure that it not only represented geographic diversity (urban and rural), but also the total spectrum of care as it relates to the specific condition/subpopulation discussed.

#### ***6. Modify MCO Contracts, If Any, with State Medicaid Agencies to Meet Requirements***

It has been our experience that SIM expectations have not been clearly defined in MCO contracts. Through updates to the Medicaid Managed Care Model Contracts, the SIM should require State Medicaid Agencies to add the VBP terms and requirements of the VBP system into the MCO contracts to stimulate their Targets Are Not Meaningful– In the past, IME has provided the VIS results (as percentages) without set targets other than general improvement. Without specific performance expectations, targets are meaningless. Although the VIS 2.0 will provide a point system rather than a percentage system, this change does not address the lack of specific performance targets to gauge the magnitude of IME performance expectations in these areas. If goal is to quality measure is to support the Triple Aim, the most direct method to use evidence-based measures with associated scores, set a target, incentivize progress, and encourage high quality for each ACO.

(v) Reports Are Too Complex– VIS reports are cumbersome at best, require an extraordinary amount of time commitment from clinic support staff and leadership to interpret, and for the most part do not contain actionable items.

adoption of VBP arrangements. This requirement will set consistent parameters for providers when negotiating VBP arrangements with MCOs.

**Access to Data**

We implore CMS to mandate that SIM grantees and their commercial payers share full claims data feeds to allow providers to manage risk and their patient population. This data is needed to assess total cost of care. To be most effective, the monthly raw claims data feed must be timely and complete. The Medicare ACO claims data feed is a good starting point for SIM grantees and subcontractors to emulate. Currently data feeds from our State Medicaid agencies, as well as from commercial health plans, are typically provided on a quarterly, not monthly basis, and then the feed is less than complete (devoid of cost information) and often is delayed an additional 2-3 months to provide “mature” data. In addition, the roll- up reports create unneeded complexity and create further delay in their production as well as provider interpretation. As a NGACO, we have advanced analytics and predictive modeling tools and can factor in completion percentages and trends. The delay in Medicaid and commercial data and their incomplete nature hinders a provider’s ability act on data, making gap reports virtually inconsequential. While we understand that not all providers have advanced analytics capabilities, we strongly believe that providers should have the option to request monthly data feeds. Ideally, this data feed should resemble the CMS data feed or be placed in an All-Payers Database that uploads to a common data framework. We would advocate that SIM projects include timely, complete data sharing requirements and that providers be solicited for ongoing input.

We appreciate the opportunity to provide input on the SIM. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President and Government Relations Officer, Government & External Affairs at [sabra.rosener@unitypoint.org](mailto:sabra.rosener@unitypoint.org) or 515- 205-1206.

Sincerely,



Sabra Rosener  
VP, Government & External Affairs



# National Health Council

1730 M Street NW, Suite 500, Washington, DC 20036-4561 ■ 202-785-3910 ■ [www.nationalhealthcouncil.org](http://www.nationalhealthcouncil.org) ■ [info@nhcouncil.org](mailto:info@nhcouncil.org)

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October 28, 2016

The Honorable Sylvia M. Burwell  
Secretary, Department of Health and Human Services  
200 Independence Ave SW  
Washington, DC 20201

SUBMITTED ELECTRONICALLY TO: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

RE: CMS Request for Information -- State Innovation Model Concepts

Dear Secretary Burwell,

The National Health Council (NHC) is pleased to provide comments on the State Innovation Model Concepts Request for Information (the RFI).

The NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient advocacy organizations, which control its governance and policy-making process. Other members include professional and membership associations, nonprofit organizations with an interest in health, and representatives from the insurance, pharmaceutical, generic drug, medical device, and biotechnology industries.

CMS launched the State Innovation Model (SIM) initiative in 2013 to test the ability of state governments to "use their policy and regulatory levers to accelerate healthcare transformation efforts in their states, with a primary goal to transform over 80% of payments to providers into innovative payment and service delivery models." The SIM concepts presented in the RFI would rely upon the waiver authority of Section 1115A of the Social Security Act, which permits the Agency to test innovative payment and service delivery models designed to reduce program expenditures while preserving or enhancing care quality for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

We appreciate the Agency's proactive approach to incorporating stakeholder input at the early conceptualization phase of these potential SIM initiatives. This letter offers NHC's general recommendations, and highlights specific concerns and recommendations with respect to the concepts set forth in the RFI.

As more fully set forth below, our general recommendations include:

- ☐ The NHC urges CMS to develop a patient-engagement infrastructure to incorporate the patient voice in value-based payment initiatives;
- ☐ CMS should ensure that state-based initiatives are developed with a process of meaningful patient engagement and evaluated from a patient-centered perspective; and
- ☐ CMS should ensure that SIMs are evaluated using criteria and measures consistent with the directives of Section 1115A.

Our specific concerns and recommendations with respect to the RFI include:

- ☐ SIMs must include meaningful patient safeguards; and
- ☐ New state-specific models must ensure that patients with complex and multiple chronic conditions receive appropriate, high-quality care.

## General Recommendations

***The NHC urges CMS to develop a patient-engagement infrastructure to incorporate the patient voice in value-based payment initiatives.***

The NHC supports payment system reforms that incentivizes value-based and patient-centered care. However, at present, “value” is an elusive concept without a uniformly defined meaning or approach across the health care industry. Patient perspectives on value can differ significantly from that of payers and their providers and encompasses concerns beyond cost effectiveness calculated based on national averages. Patients with chronic conditions and disabilities, particularly those with multiple chronic conditions, have unique needs; both the value and quality of care are not easily captured with metrics developed for specific disease states or the general patient population. These patients want and need clinically effective treatment options that are relevant to their personal circumstances and individual goals.

When FDA announced its Patient Engagement Advisory Committee (PEAC), it noted that:

Although it may seem odd in retrospect, the development of new technologies intended to improve patients’ lives has largely relied upon expert opinions rather than asking patients and families directly what they consider most important.<sup>1</sup>

The NHC believes the same can be said of value-based payment initiatives, and has, through its comments, urged CMS that, as a threshold matter, it must first work with the stakeholder community to create a shared and agreed-upon definition of value in terms of clinical effectiveness as well as relevance to patients and their family caregivers. We continue to express our concern that failing to address this systemic informational gap will deprive the Agency, the states, and the patients they serve of core information that should guide and drive payment and

<sup>1</sup>Nina L. Hunter, Ph.D., and Robert M. Califf, M.D., FDA Announces First-ever Patient Engagement Advisory Committee, Sept. 18, 2015, <http://blogs.fda.gov/fdavoices/index.php/2015/09/fda-announces-first-ever-patient-engagement-advisory-committee/> (accessed October 25, 2016).

care delivery innovation. Ultimately, this failure could undermine our shared goal of improving quality and reducing costs.

The NHC, with stakeholder input, has created a Patient-Centered Value Model Rubric (attached) that the patient community, physicians, health systems, and payers can use to evaluate the patient-centeredness of value models and guide model developers on the meaningful incorporation of patient engagement *throughout* the value framework and economic model creation processes. We identify six key domains that are essential for integrating the patient voice in value-based payment program development and implementation:

1. **Patient Partnership.** Patients should be involved in every step of the development and dissemination process;
2. **Transparency to Patients.** The assumptions and inputs – and each step in the process – should be disclosed to patients in an understandable way and in a timely fashion;
3. **Inclusiveness of Patients.** The value framework and supporting model should reflect perspectives drawn from a broad range of stakeholders, including the patient community;
4. **Diversity of Patients/Populations.** Differences across patient subpopulations, trajectory of disease, and stage of a patient's life should be considered;
5. **Outcomes Patients Care About.** The outcomes integrated should include those that patients have identified as important and consistent with their goals, aspirations, and experiences.
6. **Patient-Centered Data Sources.** A variety of credible data sources should be considered to allow for timely incorporation of new information and account for the diversity of patient populations and patient-centered outcomes, especially those from real-world settings and reported by patients directly. The data sources included should reflect the outcomes most important to patients and capture their experiences to the extent possible.<sup>2</sup>

CMS has clearly and consistently stated its commitment to a continuing dialogue with the stakeholder community as a key component of payment and care delivery innovation initiatives. The NHC strongly urges CMS to implement the infrastructure necessary to deliver on that commitment. Specifically, we urge CMS to:

- ☐ Form an administrator-level patient advisory council (PAC) to guide the organization on patient engagement and patient centeredness in all of its programs, including MIPS, the implementation of APMs, quality-measure development for ACOs, and SIM initiatives;
- ☐ Include patients and caregivers in the measure-development process;
- ☐ Develop measures and evaluation tools that improve care for patients with multiple chronic conditions;
- Develop patient-reported, outcome-based performance measures (PRO-PMs) to support patients' immediate and long-term goals;
- ☐ Ensure that measures and evaluation tools are risk-adjusted for patient characteristics and with an understanding that many patients with progressive or degenerative conditions will likely see worsening health status despite receiving the highest quality care possible.

<sup>2</sup>Id. at 3.

***CMS should ensure that state-based initiatives consider the needs of patients with chronic conditions and are developed with a process of meaningful patient engagement.***

The relative breadth of CMS' articulated vision, coupled with the lack of reliable and meaningful patient-centered data on the models currently implemented or under development raises concerns on the potential impact this initiative could have on the patients and caregivers the NHC represents. CMS has stated that these early programs show promise with respect to transformation into innovative payment and care delivery models, with three states reaching over 50% of the state's population and two reaching 80% of their Medicaid population. The NHC is concerned that the data currently available to CMS are not necessarily meaningful measures of quality or value from a patient perspective, as required under Section 1115A. Data on hospital readmissions and emergency room visits may have relevance in assessing care quality and associated costs for acute illnesses and routine surgical procedures. However, it is not clear whether decreased hospital readmissions are related to better care or a consequence of the clinician disincentives aligned against readmission.

We note that CMS' recently issued Final Rule with Comment Period implementing MACRA (CMS-5517-FC) included a call for stakeholder comment on potential CMS-initiated guidance for payment arrangements qualifying as other-payer Advanced APMs, as well as formal evaluation and approval mechanisms for Medicaid APMs. As CMS looks to expand SIMs and develop APMs in Medicaid and other payment systems, it is imperative that the Centers work with the patient community to develop evaluation criteria from a patient-centered standpoint and require states to use them to evaluate SIMs and APMs that they propose implementing in their Medicaid programs.

***CMS should ensure that SIMs are evaluated using criteria and measures consistent with the directives of Section 1115A.***

While CMS has considerable flexibility under Section 1115A with respect to payment and care delivery model initiatives that incentivize quality and efficiency in health care services, the Agency must monitor and evaluate its tested models and terminate or redesign any model that does not improve patient care, or even potentially harms patients.

We acknowledge that there are currently a variety of evaluation tools available, though many are based on clinical guidelines developed by specialty societies. These tools, however, generally rely on clinical literature reviews that include scientific studies largely precluding enrollment of complex patients, such as those with multiple chronic conditions. They also lack both the granularity necessary for accurate risk adjustment and the focus on patient-level outcomes and patient-centeredness criteria that are required under Section 1115A. Section 1115A directs CMS to evaluate tested models utilizing both patient-level outcomes and "patient-centeredness criteria."<sup>3</sup>

In developing and selecting evaluation tools and measures, CMS must also ensure that clinicians treating patients with chronic diseases and disabilities are rewarded for selecting the most appropriate care for their patients rather than penalized for their patients' health status.

<sup>3</sup> Social Security Act, Section 1115A(b)(4)

## **Concerns with Specific Concepts in the Request for Information:**

### ***SIMs must include meaningful patient safeguards.***

CMS has historically approached alternative payment models under Section 1115A of the Social Security Act with careful consideration of potential unintended consequences to patients. The Agency has attempted to incorporate patient safeguards to ensure continued access to medically necessary services as the Agency evaluates a model's effectiveness in improving care quality while reducing costs. The Oncology Care Model, for example, incorporated eight measures to assess the impact of service utilization, patient experience, and psychosocial assessment impact on quality through the Model. Appropriate notification requirements have been incorporated into models and demonstrations to inform beneficiaries, and provide an opportunity to "opt out" of a particular model test or other demonstration.

As CMS encourages increased state-based efforts toward payment and care delivery innovation, it is imperative that the Agency incorporate meaningful, actionable patient protections. State-based safeguards should be an essential element of any model, and should be designed to sufficiently address patient access issues in real time. Since the frequency, nature, and severity of access issues and other patient concerns, as well as their timely resolution are relevant in assessing an initiative's success, we strongly urge CMS to require state reporting on access issues, patient complaints, and their resolution. We similarly urge CMS to adopt mechanisms at the federal level so that impacted patients can elevate unresolved access issues directly to CMS.

The NHC has reservations about CMS' expressed interest in utilizing supplemental awards to assess the impact of specific care interventions across states. While this proposal could offer promising opportunities for patients and caregivers in areas where care disparities prevail and standardized approaches would tend to benefit all impacted patients, the NHC is concerned that employing "robust tools" such as randomization on care interventions creates significant ethical concerns. Specifically, it would appear that an "experiment" focused primarily on the Medicaid population and designed to compare care interventions would supplant the ordinary patient-physician decision making relationship. We suggest that:

- ☐ These initiatives would likely require review and approval by an Investigational Review Board;
- ☐ Impacted patients must be informed, in writing, of the existence and purpose of the experiment and offered the opportunity to either consent or opt out;
- ☐ Physician incentives should not be based upon enrolling patients in the program; and
- ☐ Careful consideration must be made to inclusion and exclusion criteria to ensure that patient participation is consistent with sound medical judgment and patient preferences.

### ***New state-specific models must ensure that patients with complex and multiple chronic conditions receive appropriate, high-quality care.***

The NHC is concerned that state accountability for the total cost of care may jeopardize access to and appropriateness of care for individuals with chronic (including multiple chronic) conditions. For these patients, it is essential that any innovation initiative consider patient-specific health status, outcomes, and goals, and that they receive high-quality care consistent with individual goals and perspectives of "value."

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High-quality care for chronic conditions and associated costs are not easily measured in the context of short-term goals. Decisions on treatment options may impact disease progression and trajectory, with avoided costs most appropriately assessed in the long-term. The NHC urges CMS to ensure that any tested SIMs (a) facilitate incorporation of the patient voice in assessing value, (b) ensure that measured outcomes comply with Section 1115A's directive on patient-specific outcomes and a patient-centered approach to quality and value; (c) incorporate robust, real-time patient protections, and (d) ensure that patients with complex and/or multiple chronic conditions can access care consistent with their goals and aspirations.

## **Conclusion:**

As the voice for people with chronic diseases and disabilities, the NHC appreciates the opportunity to respond to CMS' Request for Information. The NHC and our member patient organizations stand as willing partners to work with CMS to create a shared definition of value from the patient perspective, and enhance Agency efforts toward incorporating meaningful patient engagement into payment and care delivery innovation.

Please do not hesitate to contact Eric Gascho, our Vice President of Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at [egascho@nhcouncil.org](mailto:egascho@nhcouncil.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'MBoutin', with a long horizontal stroke extending to the right.

Marc Boutin, JD  
Chief Executive Officer





1500 Security Blvd.  
Baltimore, MD 21244

Submitted electronically to: SIM.RFI@cms.hhs.gov.

Re: Request for Information on State Innovation Model Concepts

Dear Dr. Conway:

Community Catalyst respectfully submits the following comments regarding the request for information on State Innovation Model Concepts.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation focuses on health system transformation and bringing the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those that are most vulnerable.

We appreciate the opportunity to offer our perspective as CMS considers future directions for the State Innovation Model (SIM) program. We support CMS' efforts to move the health care system away from one that is based solely on fee-for-service, and toward a system that focuses on better coordination, quality and value of care. The SIM grants play an important role in helping states accelerate this transformation. We appreciate CMS' efforts to build on the important work already being done through these grants, but have concerns about the possibility of implementing multi-payer initiatives without robust mechanisms for consumer engagement and sufficient resources to support that engagement. Additionally, while we understand CMS' desire for better alignment between Medicare and state-based advanced payment models, we have concerns about the implementation of the Quality Payment Program that would prevent us supporting alignment efforts until those concerns are addressed.

## **SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

- a. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?*

## Strong Consumer Engagement Mechanisms

Strong consumer engagement mechanisms are necessary for successful multi-payer delivery reforms. Increasing evidence points to the importance of consumer empowerment and engagement as a means of quality improvement and cost savings.<sup>1</sup> Consumer and patient voices provide a vital perspective for ensuring new delivery models are patient-centered, culturally competent, and meet the specific needs of the community. This is particularly important for SIM initiatives, where states have a lot of leeway in choosing which innovations they want to implement, and will be crucial as states move toward implementing multi-payer models that, by definition, will impact consumers with diverse circumstances and health care needs.

While the 2015 guidance mentions how patient engagement might play a role in specific delivery models (accountable care organizations or patient-centered medical homes, for example), it makes no mention of the importance of consumer input as states are deciding how to implement multi-payer models. As CMS considers next steps for advancing state based multi-payer reforms, we urge CMS to make consumer engagement at all levels an integral piece of future SIM initiatives and rule making.

Connecticut provides an excellent example of a state that is incorporating consumer and patient perspectives into their SIM initiatives at multiple levels. Connecticut uses a Consumer Advisory Board (CAB) model to “ensure significant consumer participation in the planning and implementation process.”<sup>2</sup> The CAB is tasked with: providing advice and guidance to the SIM office; arranging for and supporting consumer representation on taskforces and councils; recommending and participating in consumer engagement activities; and reviewing and considering consumer and advocate input. Connecticut also utilizes a consumer engagement coordinator to conduct community outreach and solicit input from the broader consumer community on an ongoing basis. In addition to engaging consumers in the planning and implementation process, Connecticut requires consumer engagement at the individual model or initiative level, making it an integral part of their Advanced Medical Home (AMH) and the Community Clinical Integration Programs (CCIP) and including the consumer family advisory groups as a required component of CCIP.

We also encourage CMS to look at examples of how other health system transformation efforts, such as the dual eligible demonstration projects or Medicaid ACOs, have utilized consumer engagement. For example, Massachusetts established a statewide stakeholder Implementation Council with a requirement for 51 percent consumer and consumer advocate membership for its One Care demonstration for dually eligible individuals with disabilities, and built advocacy into its care model, such as through the inclusion of an independent long-term services and supports coordinator from community-based organizations.<sup>3</sup> Oregon’s new Coordinated Care Organizations (CCOs) offer another model of multi-level consumer engagement, involving

<sup>1</sup> See, e.g., Ahn S, Basu R, Smith ML, Jiang L, Lorig K, Whitlaw N, Ory MG. The impact of chronic disease self management programs: healthcare savings through a community-based intervention. BMC Public Health. 2013; 13:1141; Carman KL, Dardess P, Maurer M, Sofaer S, Adam K, Bechtel C, Sweeney J. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. Health Aff. 2013; 32(2): 223-231. Greene J, Hibbard JH, Sacks R, Overton V, Parrotta CD. When patient activation levels change, health outcomes and costs change, too. Health Aff. 2015; 34(3): 431-437.

<sup>2</sup> Connecticut State Innovation Model Program Management Office. Available at: <http://www.healthreform.ct.gov/ohri/cwp/view.asp?a=2765&q=333602>

<sup>3</sup> Massachusetts “Frequently Asked Questions about the Implementation Council” <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/implementation-council-faq.pdf>

consumers in public meetings and workgroups at the state level, as well as requiring at the CCO level a governance board that includes at least two members of the community, and a Community Advisory Council (CAC) that meets at least once every three months and is surveyed annually to assess their satisfaction with the level and quality of their engagement.<sup>4</sup>

We ask that CMS require all states to provide a plan for engaging consumers at the planning and implementation levels, as well as explain how they will ensure consumer input at the health system and plan levels. Engagement needs to be more than simply informing consumers or hosting focus groups. Consumers should be engaged collaboratively to design important aspects of the delivery of care.

### A Focus on Equity

Low-income communities and communities of color still face significant disparities in health outcomes. Improving health equity must be a major goal of any health system transformation effort if we hope to achieve the triple aim of improving patient experience, improving population health outcomes and reducing costs. One benefit of the SIM grants is the flexibility they give states to focus transformation efforts on the communities and populations who can most benefit. While we understand the desire to set ambitious goals and move more patients into APMs through multi-payer models, we are worried about creating incentives for states to focus their efforts on the easiest-to-reach populations. This could have the unintended effect of actually broadening health disparities. As CMS considers how to use SIM grants to advance multi-payer models, we urge CMS to make health equity a more prominent focus. We ask that CMS require states to show how they will use future SIM initiatives to invest in communities disproportionately impacted by health disparities. We also ask that CMS consider ways to promote models that specifically address the social determinants of health, such as housing, transportation and food security.

#### ***d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation?***

As described above, robust consumer engagement is vital to the success of multi-payer delivery reforms, but that engagement won't be successful without sufficient resources. Dedicated funding for consumer engagement activities is absolutely necessary for ensuring that multi-payer delivery and payment reforms are patient-centered and designed to meet the health needs of the diverse populations multi-payer efforts will impact.

Community Catalyst regularly speaks with consumer health advocates in 40 states across the country. These advocates are in direct contact with consumers in their state and, accordingly, are able to provide an accurate perspective on the issues consumers face in accessing health care on a daily basis. We've repeatedly heard from our advocates that one of the largest barriers they face to effective consumer engagement is a lack of resources.<sup>5</sup>

<sup>4</sup> Wiitala, K, Metzger, M, and Hwang, A. "Consumer Engagement in Medicaid Accountable Care Organizations: A Review of Practices in Six States," Community Catalyst, September 2016, available at: <http://www.communitycatalyst.org/resources/publications/document/ConsumerEngagementMedicaidACOs.pdf?1474915709>

<sup>5</sup> ibid

On its most basic level, engaging consumers in payment and delivery reform efforts requires educating consumer representatives about the issues at hand and ensuring meetings are held at accessible times and adequately convenient locations for consumer representatives to participate. We would recommend that structured opportunities be created for consumers and consumer advocates to be informed by the SIM staff of the actions they are taking to protect consumer interests and seek consumer input on programmatic or policy choices that emerge in the implementation of the SIM. Many advocates and consumer representatives are using entirely volunteer time to learn about these issues and participate in meetings and forums. As volunteers, consumers differ from all the others at the table who get a paycheck to participate and prepare for the meeting. Consumers should be compensated for their time and preparation. To be maximally effective, consumer engagement should represent the voices of patients and caregivers from diverse backgrounds and communities. This perspective is absolutely necessary in ensuring health system transformation efforts appropriately address the unique needs of culturally distinct communities for resources for outreach, training, and leadership development.

The Massachusetts Implementation Council mentioned earlier is successful in part because of the associated resources provided. The state provides trainings and physical accommodations as needed to council members, pays stipends to consumer members for attending meetings and doing preparatory work, and provides reimbursement for travel expenses.<sup>6</sup>

We note the focus on technical assistance for providers in adopting new models of care, and we argue that the same degree of attention, engagement and resources should also be applied to prepare consumers for these new models, with a particular focus on vulnerable consumers who may be most impacted by these changes and who often face the most barriers to accessing information or services.

***g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?***

While we understand the move toward greater alignment of payment models, particularly the desire to align reforms to Medicare models that impact large numbers of beneficiaries and providers, we caution against alignment for the sake of alignment. As CMS considers how Medicare-specific models might overlap and interact with state-specific models, we ask CMS to ensure that robust consumer engagement mechanisms and strong consumer protections are not lost in the attempts to align.

This is particularly important given some of the concerns we have with the rules surrounding the Quality Payment program (QPP). We ask CMS to refer to the comments we submitted on June 27, 2016<sup>7</sup> and to pay close attention to consumer responses to the final MACRA rule released on October 14 as they consider how to support states which want to undertake multi-payer models with Medicare participation. While we think the QPP is an important first step in moving from a

<sup>6</sup> Dembner, A and Regan, C. "A Seat at the Table: Consumer Engagement Strategies Essential to the Success of State Dual Eligible Demonstration Projects," Community Catalyst, May 2013, available at: <http://www.communitycatalyst.org/document/publications/a-seat-at-the-table-duals-consumer-engagement.pdf>

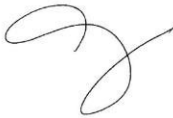
<sup>7</sup> Community Catalyst, Comments re: Notice of Proposed Rulemaking on Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Medicare Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P), Submitted electronically on June 27, 2016, available at: <http://www.communitycatalyst.org/resources/commentletters/document/CCEHI-Comments-on-the-Quality-Payment-Program-June-27-2016.pdf>

system based on volume to one based on value, the rules fall short in terms of requirements for, and promotion of, patient engagement activities, consumer-oriented quality measures, and measures to address health disparities. We urge CMS to ensure that multi-payer models advanced through future SIM initiatives address some of the weaknesses in the current Quality payment Program rules.

Additionally, many of the state advocates we work with have raised concerns that a push toward greater alignment might undermine important progress consumer advocates have made or could cause states to abandon new and innovative ideas they are currently pursuing through their SIM grant. For example, advocates in Oregon are working to ensure consumer voices are part of the conversation surrounding quality metrics and don't want to see any progress they make towards consumer-oriented measures erased in efforts to align quality metrics. Additionally, advocates in states that are exploring interventions to address the social determinants of health fear this work could be pushed aside in the movement to focus on aligning payment models. We caution against CMS prioritizing alignment over innovative state initiatives that are aimed at meeting the identified priority health needs of consumers. Aligning payment models should be a strategy that helps improve health care for consumers rather than an end in itself.

Thank you for the opportunity to comment on this important provision. Please do not hesitate to contact me at [ahwang@communitycatalyst.org](mailto:ahwang@communitycatalyst.org) should you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to be 'AH' or 'Ann Hwang', written in a cursive style.

Ann Hwang, MD  
Director, Center for Consumer Engagement in Health Innovation

CC: Stephen Cha, M.D., Director, State Innovations Group



at the UNIVERSITY of CHICAGO

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system and payment reform efforts. This information will be helpful to CMS as they consider how best to partner with and support states in developing the operational and organizational capacity needed to implement multi-payer AAPMs as envisioned in MACRA.

## **I. Multi-Payer State-Based Strategies to Transition Providers to AAPMs**

### **Q1. Interest among states for state-based initiatives with a goal to transition providers to AAPMs.**

*Challenges in achieving multi-payer alignment.* Engaging commercial payers, in particular aligning goals and benefits of participation across payers and providers, is a key challenge. States, as regulators or purchasers, have limited influence with national payers as well as in markets where there is no dominant payer. CMS can help increase states' collective influence with these payers by convening states and payers, potentially at a regional level, and using Medicare Advantage as a platform for alignment. State employee plans may be riper for alignment than Medicaid, as the needs of Medicaid beneficiaries are often vastly different than needs among commercially insured populations. As state employees eventually transition to Medicare, there is mutual interest and opportunity for alignment among states and payers.

*Challenges of state Medicaid programs in readying themselves to offer AAPMs.* Many Medicaid providers are likely unwilling or unable to assume financial risk for their complex patient populations. AAPMs geared to Medicaid providers may consider upfront payments and stop-loss provisions as mechanisms to offset concerns about assuming financial risk.

In many states, provider networks that comprehensively address the complex needs of the Medicaid population are lacking. Income states, building and maintaining networks is further challenged by reduced Medicaid reimbursement rates, driving providers out of the already challenging Medicaid market. The introduction of AAPMs should consider how to maintain and reinforce the networks that do exist as well as attract new providers to serve the Medicaid population.

With 61 percent of Medicaid enrollees in comprehensive managed care (77% in any type of managed care)<sup>1</sup>, Medicaid managed care contracts are one state lever to foster alternative payment strategies. The strength of the lever, however, depends on the approach states take to these contracts. Some

<sup>1</sup> Kaiser Family Foundation. *Total Medicaid MCO Enrollment, March 2016*. Available at: <http://kff.org/other/state-indicator/total-medicaid-m-co-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

States set narrow parameters in their MCO contracts, while others allow more flexibility or even voluntary participation that dilutes the potential for value-based purchasing (VBP). It is important to note that due to market conditions, not all approaches are feasible in all states. It is also worth noting that the existing Medicaid rate setting regulations penalize MCOs that successfully implement VBP models such as AAPMs and reduce utilization, a dynamic that does not exist in the Medicare and can make state implementation of AAPMs challenging.

Health IT infrastructure to support AAPMs is also lacking among many Medicaid providers. States will be greatly challenged to support providers' capacity to conduct the data collection and analysis that is a crucial feature of AAPMs.

*Resources and tools states need from CMS to design and launch robust multi-payer delivery and payment reforms.* States often face significant limitations with respect to internal resources needed to design and launch such reforms. As a result, they must contract with consultants and other vendors to support these tasks. The procurement process can take a significant amount of time. One consideration for future models is to pre-empt administrative delays by conducting preliminary research on possible contractors for a select group of model functions and make available a pool of contractors from which states could select if they chose to do so. For some services, (e.g., actuarial support), many states Contract with the same providers.

*Reasonable performance period for states to develop a plan and build operational capacity for the APM incentive under implement multi-payer delivery and payment reforms that could align with the proposed Quality Payment Program.* In SIM, the pre-implementation period was critical for states to engage stakeholders, build a governance structure, and staff the work. It was a benefit to Round 2 states to have the 12-month pre-implementation period. Important to note is that when considering the Design and Pre-test awards, some had 18 months or longer to do this capacity-building work.

## **Q2. Financial accountability for health outcomes.**

*Approaches to delivery and payment reforms that include accountability for population health outcomes.* Several SIM states, including Oregon and its Coordinated Care Organizations and Maryland's all-payer hospital-based arrangements, have encouraged accountability for population-based outcome measures by way of tying such measures to global payments. Under such models, states can leverage targeted governance requirements, quality measures, infrastructure requirements, and care delivery requirements to further drive such population-based approaches, but would require significant actuarial and financial simulation support as well as help developing effective performance measurement strategies.

*Approaches by rural and tribal providers to include social services and public health strategies.* Rural/tribal providers are particularly familiar with gaps in social services/supports given inherent challenges in the populations they treat. Such providers also typically have relationships (albeit informal) with leading social service providers in the community and have likely referred patients to such providers in the past. Several states have had to explore these issues as part of their SIM work and

have successfully involved these providers in engaging relevant partners and organizations in the process of connecting with one another, designing practical workflows for referring patients to various services (including travel arrangements, telehealth), identifying relevant measures and developing tools to more formally track improvements in the integration of social and public health services.

*Approaches by urban providers with overlapping catchment areas.* As we've seen with DSRIP in New York State, and more specifically among the networks of providers (or PPSs) that have formed in New York City, urban providers with overlapping catchment areas who may directly compete with each other, have partnered to better serve their populations and leverage one another's strengths to maximize the services offered. Specific challenges include: complexities around the attribution model for each network given that patients flow between multiple providers from different networks; challenges with capturing accurate patient data and compiling into a comprehensive record given legal and technical barriers as well as gaps in existing workflows across multiple treating providers; and questions around accountability for total cost of care given the numerous services and providers involved in each patient's care. States have been grappling with similar issues around supporting practice transformation under TCPI for providers serving patients across state lines and how to coordinate support across multiple states and various providers. SIM has been helpful as an avenue for states to connect with one another to discuss some of these cross-state operational issues.

### **Q3. Access to data**

*Access to reliable and timely data.* Most states rely on claims data to calculate spending benchmarks and to monitor total cost of care trends. Claims data are generally not considered to be very timely and do not always include paid data, necessitating users of the data to make inferences using charges data. States also seem to struggle to obtain Medicare data, and even when they do get it, there is a learning curve to using it. CMS can support states' access to reliable and timely data by developing data standards and streamlining access to Medicare data.

Clinical quality data are often less timely than claims data, and it must be proven reliable in order for stakeholders to be comfortable with tying it to payment. Social service data integration appears to be an area where states would likely appreciate systematic and forward-looking guidance. States may also consider leveraging surveys to gather information on social services.

*State capacity to share data and perform analyses to tie payment to outcomes.* States' approaches to share Medicaid data with CMS have been varied and ad hoc. In terms of their ability to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis, SIM has helped states to develop and support the capacity, expertise, and staff resources to perform these functions. The pace of the work states' have taken on would not have been possible without the capacity-building, expertise development, and staff experience SIM provided.

States' access to data to perform compliance and program integrity checks varies immensely. EHRs are a necessary part of the IT infrastructure many states' rely on for data. Unfortunately, EHRs do not talk to



each other and the cost to update and evolve the use of an EHR can be cost-prohibitive for practices, thereby limiting its utility.

We would encourage CMMI to meet states where they are and help states to leverage other related HIT resources (i.e. HITECH funding) to support enhancements that support state-led care delivery and payment reform.

## **II. Impact of Specific Care Interventions Across Multiple States**

### **Q1. State as a platform to evaluate the impact of care interventions.**

CMS might look to the 6|18 Initiative as a model for using existing Medicaid authorities to adopt standardized care interventions. In partnership with CDC, state teams of Medicaid and public health officials participating in 6|18 are successfully leveraging Medicaid authority to test standardized, evidence-based interventions to address six high-burden health conditions. Part of implementation planning involves determining the most effective and appropriate Medicaid authority to use to adopt the new policy or program. For example, a state looking to unbundle payments for insertion of long-acting reversible contraceptives (LARCs) from standard FQHC payment rates will do so via a State Plan Amendment. States that seek to eliminate barriers to tobacco cessation medications (like co-pays or prior authorizations) or seek Medicaid reimbursement for an asthma home visiting program may work to change Medicaid managed care contract language.

While 6|18 has been in operation less than a year, the initial cohort of nine state teams has already made clear and tangible progress in adopting certain interventions – or at a minimum, setting the stage for future adoption. States teams have benefited from having a standardized, well-defined set of evidence-based interventions from which to choose as well as from the support provided by a dedicated technical assistance team and CDC and CMS subject matter experts.

### **Q2. States' willingness to standardize care interventions and align with other states participating in an Innovation Center initiative.**

States have shown a high degree of interest in programs like CPC+ and MAPCP. With sufficient resources to support state participation and operational changes, there is likely to be some interest in participating in other federal, Innovation Center-led efforts that seek to evaluate the implementation of standardized models provided they align with existing Medicare payment models. However, in states whose providers have successful interventions underway, there is likely to be resistance among providers to adopt new tools and resources, as this requires changing systems and processes which can be complex and costly and may not effectively address their local needs. In addition, many non-academic providers are reluctant to randomize their patients into different tracks of care.

**Q2. Opportunities for CMS/HHS alignment to support state delivery system reform efforts.**

Many of the SIM states' efforts were contingent on State Plan Amendments and federal waivers, which take considerable time to process and negotiate. To the extent it is feasible, offering states an expedited process when initiatives are dependent on timely approval would be beneficial. Also, in SIM, states appreciated having CMS representatives from other initiatives (e.g., the Medicare-Medicaid Coordination Office) to discuss issues related to efforts that jointly affect target populations or providers. Similar partnerships across federal efforts would be appreciated by participating states. CMMI may consider using a contractor to track state activity across initiatives. A state-specialist project officer could facilitate communication and connections across federal initiatives within the state, including helping the state understand how and when federal programs are complementary to ongoing efforts.

Thank you again for the opportunity to provide input.

Sincerely,

The State Innovation Model Technical Assistance Team at NORC at the University of Chicago<sup>1</sup>, Center for Health Care Strategies(CHCS)<sup>2</sup> and State Health Access Data Assistance Center (SHADAC)<sup>3</sup>

Kristina Lowell, PhD, Vice-President and Project Director<sup>1</sup>

Gretchen Torres, MPP, Senior Research Scientist and Technical Director<sup>1</sup>

Tricia McGinnis, MPP, MPH, Vice-President, Programs and Team Lead<sup>2</sup>

Deborah Kozick, MPH, Associate Director, Delivery System Reform and Team Lead<sup>2</sup>

Sara Bonneville, MPP, Senior Research Fellow and Team Lead<sup>3</sup>

## Communities as Assets for Health Promotion by Chris Norwood

Presentation to OneCity Retreat July 28, 20016

Good morning, I am the Executive Director of Health People, an entirely peer-educator based health education and disease prevention community-based organization in the South Bronx. Health People is small, OneCity is big; but together we are in the same difficult and frustrating place – with now decades of studies underscoring that most health is built or lost outside the formal medical system—but equally having almost no way to address this truth.

To move from this frustration, clearly, it's time for a new vision of health---a vision that absolutely includes poor communities as recognized and valued partners in building their own health.

In this new vision of health, communities are ---not simply defined by their needs--but seen for their assets. Their greatest assets, of course, are people. Using evidence-based peer-delivered self-care, wellness and other community health promotion activities provides key opportunities to address the social determinants of health. Fully using these opportunities generally means focusing on group processes---and training and employing---even part-time---people who are representative of the community, especially those with chronic disease, AIDS, disabilities, and other targeted conditions.

A community asset approach rests on two pillars which, in themselves, inherently leverage health outcomes across a range of programming.

First, a community asset approach builds “social capital” even as it delivers evidence-based programming. **In the Health and Happiness Chapter of Bowling Alone, Robert Putnam’s extraordinary book about social connectedness, he emphasizes, “Of all the domains in which I have traced the consequences of social capital, in none is the importance of social connectedness so well established as in the case of health and well-being.”**

Dozens of scientific studies show, “The positive contributions made by social integration and social support rival in strength the detrimental contributions of well-established biomedical risk factors like cigarette smoking, obesity, elevated blood pressure and physical inactivity. Statistically speaking, the evidence for the health consequences of social connectedness is as strong today as was the evidence for the health consequences of smoking at the time of the first surgeon general’s report on smoking.”

In other words, a support group can be as vital to health as smoking cessation.

The second pillar of the community asset approach to health is that, to the largest degree possible, people who actually live in high need communities themselves are involved through training---and through work---in implementing health and wellness projects. Just as we rarely talk about the vital role of social connectedness---the profound role of unemployment in ill health hardly receives Focused attention.

An article in the Atlantic in March 2010 detailed the devastating impact of unemployment on health. Data shows “that people who were unemployed for long periods in their teens or early 20s are far more likely to develop a habit of heavy drinking by the time they approach middle age. They are also more likely to develop depressive symptoms. Prior drinking behavior and psychological history do not explain these problems—they result from unemployment itself.”

“Poor health related to unemployment... endures for a lifetime. Regardless of age, men were left with an elevated risk of dying in each year following their episode of unemployment, for the rest of their lives.”

**In sum, programming that builds social capital and community employment puts any effort at health far ahead from the start.** Yet, while no ordinary funding stream would pay for these pillars, the medical system could not use them.

DSRIP, in this respect, flawed and maddening as it is, may be a major opportunity-- the first real chance for health systems to start using community assets as a core approach to health.

There is an impressive range of evaluated health-building programs that also build social capital and employment---and demonstrably address the DSRIP goals of reducing hospitalizations and emergency room visits. Equal to the fact they exist, however, is the reality that they are not well known; as you may have heard, the state has finally, very belatedly, issued funding for community-based organizations to undertake DSRIP planning. Certainly one thing we will do which will benefit all is to make a readily usable compendium of community asset programming. Today, I will just give a brief glimpse of some of the wonderful approaches ready to bring forward. There is, for example the Stanford Diabetes Self-Management Program a six-session diabetes self-care course, delivered by trained peers who themselves have diabetes and which significantly improves patient activation and self-efficacy.

There is the peer specialist program, which in groundbreaking implementation at H + H, under Dr. Belkin, showed that peers, themselves, with a history of substance use, providing special support to patients with both behavioral and chronic health conditions, over a period of six months, reduced hospital days by 62% and behavioral health costs by almost 50%.

There are doulas, or birth coaches, who by definition under the NYC Department of Health's program must come from the communities where they assist mothers. They provide one-on-one support to expectant mothers and through birth, reducing rates of complications and cesareans.

There is the remarkable foster grandparents program; trained retirees---who again must live in the communities they are helping---provide intensive tutoring for kids having trouble in school. The kids significantly improve their schoolwork, and long-term follow up of the grandparents shows significant improvements in their health.

And there is the Arches Program, currently under the Department of Probation, in which older men with a criminal justice history mentor young men on probation. Within six months, half these young men are back in school or have found a job. Certainly the long-term benefit to the health of these young men is manifest in the research on unemployment; the immediate benefit of deterring them from the streets may well include their own lives.

It is never easy to change systems; when we look not just at DSRIP, but at all the “plans” the state and federal government are purveying for health systems, it is natural to feel overwhelmed. But I truly ask you to remember that the next few years of DSRIP are incredibly decisive to the future.

Innovative programming that is implemented through DSRIP has a new chance to be sustained; it can also propel important changes in services reimbursed through Health Homes---and bring much better ideas to our Value Based Payment Roadmap.

Most community asset programming, to work well, has to be implemented by community organizations. OneCity and other PPS’s, because they are the fund holders and dominant local planners, hold the keys to implementation for the remainder of DSRIP. The community groups, of course, don’t believe this is fair---and it’s not fair. It’s not fair to anyone that there isn’t defined funding to bring forward the community models that are desperately needed for DSRIP success---models to at once unburden medical systems of burdens they can hardly cope with anymore while implementing community-based services that work better. It’s especially not fair that we are leaving the key asset of communities---namely their remarkable determination, when given any chance, to devote themselves to fighting endemic ill health---so extraordinarily wasted.

Look at the range of people successfully implementing these programs---people with diabetes on Medicaid, former prisoners, recovering drug users and women in

the community who just want to help other women---who are often terribly alone---have a good birth experience.

For these people, we must change our vision!

Meanwhile, I would like to congratulate OneCity on its upcoming proposals for community groups to start cultural competency, health literacy and community engagement programs. These are large steps in this new direction; but more is required. I know how hard people on the OneCity Executive Committees have worked to assure better health in our nation's largest public hospital system, in daunting conditions. I just request that you consider one last principle---that even in the biggest systems, people do count. What you do, how you change approaches, even without a formal RFP, can absolutely change lives and health. The director of a supportive housing agency told me recently that the life of one his residents was totally renewed simply because she had obtained a 3-hour a week job as the patient advocate at a nursing home.

That's three hours. I will close by telling you of the benefit of two hours. These are two hours that Dr. Anna Flattau spent training Health People peer educators to address the terrible toll of diabetes-related lower limb amputations in the Bronx. Anna worked with us to develop a two-hour workshop on good foot-care for diabetics with neuropathy. More, Dr. Flattau came and herself trained the peers to deliver this workshop. With a small state grant, the peers provided the workshop for 99 South Bronx residents with diabetes and neuropathy. Follow-up of the outcomes shows that before the workshop, only 41% of participants knew how to inspect their feet; after 93% said they were confident they knew---and actually were inspecting their feet.

This peer foot education had never been done before; it couldn't have been done without Anna but it's now in the community and incorporated into our DSRIP work; and, those peers trained by Anna almost 2 years ago still glow when they talk about that training and how a prominent physician came to speak to them in a new way---a way that recognized their abilities to help their own community.

The progress, the hope, the health and happiness that community asset programming promotes is so worth struggling for. Equally, people who work so hard in this challenging environment, to me, especially deserve human satisfaction from their efforts. I hope so much that everyone in this room, as we go forward will know the extraordinary satisfaction that community asset programming brings to all involved.





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October 28, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**Attn: Request for Information (RFI) on State Innovation Model Concepts**  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Submitted electronically to: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

Re: Request for Information (RFI) on State Innovation Model Concepts

Dear Acting Administrator Slavitt,

Trinity Health appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on the State Innovation Model (SIM) Concepts. Our response and recommendations reflect a strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high-quality, and people-centered care for all. SIM, which is critical to advancing these important goals, should be continued and expanded. Valuable lessons can be learned from SIM states and their commitment to payment innovation, restructuring care delivery systems, and efforts to build healthy communities that extend beyond traditional medical providers.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming, and healing presence in our communities. Trinity Health includes 93 hospitals, 120 continuing care locations — including home care, hospice, PACE and senior living communities — that provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost \$1 billion to our communities annually in the form of charity care and other community benefit programs. We have 31 teaching hospitals with Graduate Medical Education (GME) programs providing training for 1,951 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 97,000 full-time employees, including 5,300 employed physicians, and have more than 13,800 physicians and advanced practice professionals committed to 19 Clinically Integrated Networks across the country.

Trinity Health is an organization committed to rapid, measurable movement toward value in the delivery of—and payment for—health care. Trinity Health is currently participating in 16 Medicare Shared Savings Program (MSSP) ACOs and has five markets partnering as a Next Generation ACO. In addition, we have 43 hospitals

Participating in the Model 2 Bundled Payments for Care Improvement (BPCI) initiative, 13 Skilled Nursing Facilities (SNFs) in Model 3 BPCI, and 2 hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work extends beyond Medicare as illustrated by our participation in 98 non-CMS APM contracts.

Trinity Health believes that states make great incubators for health care innovation. With facilities in nine SIM Testing states and five SIM Design states, Trinity Health has been a leader on SIM public policy development influencing the pace and process by which our states reach the goal of achieving value-based, alternative payment models (APMs) for 80 percent of their population. To support SIM efforts across our states and to advance health system transformation, we have established a [SIM Resource Center](#). This Center provides best practices, learnings, and summaries to states leaders accountable for payment, delivery, and community health transformation. Trinity Health believes that SIM efforts should be transformative, broad-based, and sustainable. Underscoring our system-wide commitment to health system transformation, Trinity Health has committed to having 75 percent of our revenue in value based arrangements by 2020 as a member of the Health Care Transformation Task Force.

We thank CMS for the opportunity to comment on this RFI and intend for our recommendations to reflect our strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high quality, and people-centered care for all. If you have any questions on our comments that follow, please feel free to contact me at [wellstk@trinity-health.org](mailto:wellstk@trinity-health.org) or 734-343-0824.

Sincerely,

Tonya K. Wells  
Vice President, Public Policy & Federal Advocacy  
Trinity Health

### ***General Remarks***

We are firmly committed to, and are making significant progress in, transforming our delivery system into a People-Centered Health System focused on delivering better health, better care, and lower costs in our communities. SIM grants are an important vehicle for states to develop and implement a broad plan for health system transformation. **Trinity Health strongly believes that SIM efforts are working and should continue as well as be expanded to additional states.** CMS can further advance the SIM demonstration efforts through the following four broad strategies:

1. Ensure engagement of relevant stakeholders to align public and private innovation efforts and resources.
2. Structure payment policy to support transformation.
3. Prioritize community engagement and population health efforts.
4. Fund and enable strategies that support transformation.

SIM grants are helping states improve the health of their residents and communities through care delivery transformation as well as investments in healthy living. The grants are helping states and governors drive collaboration with payers, providers, patients, and other stakeholders. SIM can help in driving these key actors to the table. We encourage CMS to refine and extend the SIM demonstration program so that more states may

Participate, and participating states can progress to the Testing phase. Our comments are in support of improving the SIM demonstration program's ability to:

1. Transform health care delivery.
2. Promote healthy living and communities.
3. Drive multi-payer, collaborative learning across states.

### ***Multi-Payer State-Based Strategies to Transition Providers to Advanced Alternative Payment Models***

Trinity Health seeks to be a national leader in SIM public policy development, sharing and supporting states in achieving their shared goal with CMS of moving 80 percent of their population into value-based APMs. Trinity Health's SIM states are using a range of APMs, including: accountable care organizations (ACOs) in Massachusetts, Delaware, Connecticut, Iowa, Oregon, and Michigan; patient-centered medical homes (PCMHs) in New York, Ohio, Idaho, Connecticut, and Michigan; and episodes of care in Ohio. We support this varied approach and believe each has learnings to be shared.

Our engagement across these states gives us a unique perspective in contributing to the potential next phase of the SIM demonstration. We have found that evaluating and measuring progress across states is an important component in achieving bold reform and is key to successful SIM work. Trinity Health has developed, and is using, a dashboard to measure readiness and progress in our SIM states on the following dimensions: payer participation and covered populations, governance structure, payment and delivery reform implementation, and community health and well-being. Our collective experience has demonstrated that sharing best practices across states and participating in true learning collaboratives are important factors for success. We recommend that the Center for Medicare and Medicaid Innovation (CMMI) develop a tool that measures state progress in a consistent and transparent way. We believe that greater sharing of key learnings and consistency across states is needed.

Trinity Health believes that states are successful incubators for new care and payment delivery models. Though the range of innovations differs greatly between states, Trinity Health's SIM efforts have demonstrated that buy-in and support—both financially and in terms of infrastructure—from the state are key to stability and sustainability of reform efforts.

### ***Essential Components of Successful Multi-Payer Reforms***

#### Multi-Stakeholder Engagement

**Based on our experience, Trinity Health believes that multi-stakeholder engagement is key to developing sustainable reforms and ensuring robust participation from payers and providers.** States should leverage their ability to convene multi-sector representatives to form a broad coalition and build consensus around the purpose and desired outcomes of transformation efforts. This is best reflected in the SIM governance structure. Not surprisingly, SIM governance structures vary across states. Yet almost all are convening stakeholders for input on design and implementation issues, including payment strategies, quality metrics, and integration of behavioral health services, health information technology programs, and community health improvement efforts. Stakeholders should include: members of the public and private sector, including providers, consumers, advocates, representatives from health plans and local public health. A best practice, Delaware established the Delaware Center for Health Innovation, an independent, non-profit public-private partnership, to oversee its five SIM committees. In Ohio, the Health Care Payment Innovation Task Force (comprised of state agency representatives) and the Governor's Advisory Council on Health Care Payment Innovation (including consumers, providers, and plans) jointly oversees the state's five SIM "implementation teams." Best practice governance structures promote stability, joint accountability, and sustainability – regardless of political or other challenges

That impact transformation efforts. **CMS should consider sharing governance structure best practices, such as those in Delaware and Ohio, with other states to ensure that SIM efforts are anchored by multi-stakeholder support and participation – and can progress across administrations and other change.**

Getting, and keeping, payer engagement and participation is especially critical. Our experience suggests negotiations over APM terms between payers and providers can be challenging. Trinity Health has found that SIM efforts are most successful when states set goals and help advance APM terms that move more individuals into value-based payments in a way that is sustainable for all stakeholders. For instance, New York successfully advanced Medicaid APMs by outlining APM requirements on issues such as patient attribution, quality measures, medical loss ratio and contracting timelines — helping make progress between payers and providers. **CMS can increase payer and provider participation in APMs by providing model terms for APMs, as well as ensuring alignment of federal and state models and new APM models, i.e. CPC+, across payers. Additionally, CMS should require payers and providers to report their APM growth.**

#### Robust Health Information Technology Infrastructure

Trinity Health believes that data sharing and exchange across payers, providers, and other stakeholders is essential for providing coordinated care and ensuring accountability to further the goals of better health, better care, and lower costs. SIM grants enable expanded use of technology and interoperability; both of which should be expected outcomes from SIM testing states.

States have taken a range of approaches to developing health information technology (HIT) plans and capabilities, developing nuanced approaches based on geography, patient populations, or other state-specific factors. Idaho, for example, is planning to establish virtual PCMHs to provide specialty and behavioral health services to rural patients as part of its SIM efforts. These virtual PCMHs will integrate electronic health records (EHRs), patient portals, and clinical decision tools. The state is also working to establish a statewide HIT system in 2016-2017, which will incorporate tracking of clinical quality measures among PCMHs. Similarly, Connecticut has established a HIT Advisory Council to develop a strategy for integrating mechanisms for quality measure reporting into the state's broader HIT system.

**As CMS considers how SIM grants can be used to build robust, interoperable HIT infrastructure, Trinity Health recommends that the Agency identify ways to support the creation of standardized HIT ecosystem that supports clinical decision-making in an actionable way, informing population health and promoting and monitoring movement to value-based payments.** Support mechanisms could include promoting an HIT workforce, funding to support providers in using HIT data and capabilities in actionable ways, ensuring the security of health data, and expanding the use of HIT capabilities to non-traditional providers (e.g. post-acute care, behavioral health).

#### All-Payer Claims Databases

Some states are using SIM funding to develop All-Payer Claims Databases (APCDs). Trinity Health believes this should continue and spread. Collecting and allowing data to be analyzed across payers is critical to driving value-based purchasing and transparency. Furthermore, APCDs can advance population health goals, and provide the ongoing infrastructure to help address public health crises that may benefit from data sharing, such as the current opioid epidemic. The *Gobeille v. Liberty Mutual Insurance Co* decision has created uncertainty around, and slowed development of, APCDs. While holding that ERISA preempts state APCD reporting requirements, the Supreme Court opened the door for a federal solution. **CMS should consider ways to support states in establishing and leveraging APCDs to support health transformation efforts. This includes support for a short- term solution to the *Gobeille v. Liberty Mutual Insurance Co.* decision; specifically the Department of Labor**

**(DOL) could implement a pilot program to collect health care claims data in cooperation with state APCDs. A longer-term solution includes standardized data collection across all states.**

#### Population Health Efforts

**Trinity Health believes that improving population health requires a whole-person approach to meet the full range of an individual's needs. Key elements of this approach include integration of physical and behavioral health services, as well as utilization of community-based social services to promote an integrated and seamless delivery system.** It is particularly essential for Medicaid programs to play a role in model design, as state Medicaid programs are implementing and testing innovative approaches with the potential to improve population health.

**Workforce innovation is a critical component of achieving population health goals.** A number of states have incorporated community health worker (CHW) programs into their SIM model design, including Delaware, Connecticut, Idaho, and Michigan. Idaho developed a CHW training curriculum and is poised for broader training and deployment when funding becomes available. Nurse care managers and social workers also play a critical role, and support for these professions should be explored in SIM models as well.

Some states are developing regional community health entities committed to population health activities specific to their region. Delaware's Healthy Neighborhoods program is focused on locally-tailored efforts to bring together community organizations and local populations to promote healthy living, maternal and child health, chronic disease prevention and management, and mental health and addiction management programs. In Michigan, Community Health Innovation Regions (CHIRs) will conduct community health needs assessments to identify local and regional social determinants of health, ultimately implementing action plans to address key population health priority areas and connect providers with community partners. These organizations enable states to develop targeted population health solutions that allow for the strategic and efficient use of existing—and often limited—resources. **CMS should continue to encourage innovative community health initiatives that advance population health goals at local and regional levels. Additionally, CMS should help advance workforce development programs and opportunities to support non-traditional care providers that are key to care coordination and addressing community and social service needs.**

#### *Behavioral Health Integration*

Trinity Health recognizes the importance of integrating behavioral health into APMs. In many of our states, discussions are increasingly focused on integrating physical and behavioral health services. For instance, Delaware's SIM includes care coordination and integration of physical and behavioral health care for high-risk individuals, while focusing on effective diagnosis and treatment for all populations. Massachusetts has begun work to integrate behavioral health services into its Medicaid ACOs. Other states—including Connecticut, Iowa, New York, Idaho, and Oregon—are addressing integration of behavioral health services to varying degrees in their SIM initiatives.

**Trinity Health strongly believes that collaborative care is critical to successful behavioral health integration. We encourage CMS to advance coverage of collaborative care for all providers participating in innovative, total cost of care models, such as ACOs and bundled payment programs.** Aligning payment for collaborative care within APMs will ensure accountability for achieving better health, better care and lower costs. As we gain experience with integrating more populations into APMs, we are learning that APM risk arrangements must reflect the breadth of providers participating in an APM to ensure appropriate clinical management, as well as appropriate provider accountability for costs and outcomes.

#### Cross-Payer Quality Metric Development

**Trinity Health supports greater alignment of quality measures across payers, and an overall movement to Outcome-based measures, including patient-reported outcomes measures (PROMs), that are meaningful to patients rather than process-based measures.** We believe that the development of a core, discrete set of cross-payer metrics allows states to evaluate the impact of models on health and costs across payers and providers, and that the current quality measure landscape not only adds growing administrative burden to providers participating in numerous quality programs, but also impedes the evaluation and comparison of new payment and delivery reform models.

Many SIM states have developed or are developing metric sets to understand the impact of SIM initiatives on health outcomes. Both New York and Delaware, for example, are developing scorecards for model evaluation. New York's scorecards comprised of 20 measures for all payers in the SIM, including measures from NCQA's Healthcare Effectiveness Data Information Set (HEDIS), the National Quality Forum (NQF), and the Children's Health Insurance Program Reauthorization Act. Connecticut developed a provisional set of cross-payer core measures (including CAHPS care experience measures, plan all-cause readmission, and Emergency Department Usage) but following the release of the Core Quality Measure (CQM) Collaborative's core measure set, the state is reviewing its provisional set to assess potential alignment with the CQM Collaborative. Our experience demonstrates that multiple quality sets create confusion and inefficiency among providers. **We support the work of the CQM Collaborative and suggest that CMS promote its adoption across SIM states. Adoption of nationally recognized quality metrics would go a long way to promote alignment across payers. CMS should also develop a transparent model scorecard that includes quality metrics, patient experience metrics, and APM progress.**

#### Tracking and Transparency

States must have a tool to measure progress toward achieving their goal around the percentage of payments made through value-based payments or APMs. Connecticut, in partnership with the University of Connecticut, is developing a dashboard that will track progress of key components of the state's initiative, including health insurance transformation. New York created a Payment Reform Scorecard in coordination with Catalyst for Payment Reform, which measures the percent of payments in value-based payments, tracking progress toward the state's 80 percent value-based payment goal. Transparency of such tools and evaluation data is critical to SIM success. **CMS should support the development of standardized and transparent tracking methods and tools that states can use to gauge progress, and which would allow for cross-state comparison. Specifically, CMS should develop a model scorecard that includes quality metrics, patient experience metrics, and APM progress.**

#### Payment and Delivery Reforms and Population Health

Trinity Health believes that for APMs to successfully advance population health, there must be a robust network of providers to meet the varied needs of a wide range of populations. Specifically, Trinity Health believes primary care providers – and access to them – are essential to delivering better care, achieving better health outcomes, and lowering costs. Trinity Health also believes there is a strong and important role for high-performance networks, which have demonstrated the potential to hold down costs while ensuring high-quality care and increased accountability for attributed populations. **CMS can help ensure that an appropriate network of clinicians is participating in an APM by supporting the development of narrow, high-value or high-performance networks that can promote patient engagement, facilitate effective care coordination, and manage costs effectively through the network's accountability. We encourage CMS to work with states to examine the role of network adequacy, as well as clinically integrated networks (CINs), in the successful implementation of APMs.**

## ***Assess the Impact of Specific Care Interventions Across Multiple States***

### Population-Health Initiatives Focus on Locally-Determined Needs

Trinity Health supports innovative population health approaches to addressing the social determinants of health. Trinity Health recently selected grant recipients for its Transforming Communities Initiative (TCI), a new initiative that will support community health improvement efforts in six communities with about \$80 million in grants, loans, community match dollars, and services over the next five years. All of the TCI programs will focus on policy and systematic reforms that will directly impact areas of high, local need.

Simultaneously, SIM initiatives are developing state-specific solutions to regional and local population health needs. A number of states are using community health needs assessments to develop population health improvement plans, including Oregon, Delaware, and Iowa. Furthermore, as previously mentioned, a number of states are using CHWs to assemble and train local community health advocates. In fact, Trinity Health worked with the Idaho Healthcare Coalition to develop Idaho's CHW training program.

Other models are using regional or local organizations to drive reform. Oregon's Coordinated Care Organizations (CCOs), Delaware's Healthy Neighborhoods, and Iowa's Community Care Coalition all are entities designed to coordinate public health and community partners and resources to target local public health needs. Trinity Health is currently participating in Wave 1 of Delaware's Healthy Neighborhoods initiative. **CMS should continue to encourage states to leverage SIM grants as a catalyst for population health initiatives, empowering local and regional stakeholders to address social determinants of health.**

### Focus on High-Need Patients

Trinity Health is committed to addressing the needs of vulnerable populations and reducing health disparities. States are using a number of approaches to address health disparities across vulnerable populations, and we share their goals to improve the health of all populations – especially those who are vulnerable and with high-need. Michigan's health care innovation plan, for example, will include Community Health Innovation Regions (CHIRs) that guide patients to community services relevant to their needs. By partnering with local stakeholders—schools, charities, faith-based organizations, and others—and providing efficient and effective wrap-around services, CHIRs can help tackle upstream causes of poor health in the region. Iowa's initiative includes a number of population health activities particularly focused on reducing tobacco use, obesity, and diabetes, while Connecticut has set goals aimed at decreasing rates of diabetes, obesity, tobacco use, asthma, falls, hypertension, and depression. CMS should continue to work with SIM states to ensure that the needs of vulnerable or underserved populations are a core part of their transformation plans and APM development. **Furthermore, CMS and states should recognize the vast opportunity for state experimentation and variation in identifying unique challenges and best practices to improve outcomes for vulnerable, high-need populations.**

## ***Streamlined Federal/State Interaction***

### Alignment of Flexible and Fair APMs

As federal reform initiatives continue to be announced and implemented – such as the Medicare Access and CHIP Reauthorization Act (MACRA) and Comprehensive Primary Care Plus (CPC+) – states are analyzing their efforts to determine whether and, potentially, how to align with these new efforts to advance transformation. Questions of alignment are particularly challenging in states where beneficiaries, providers, health systems, and payers may be eligible for, or are participating in, multiple initiatives with conflicting or incongruous timelines,

requirements, or measures. Providers, in particular, face enormous administrative burdens working across payers as they are often subject to different payment structures, reporting timelines, and quality measures.

In considering alignment of federal and state efforts, CMS should be cognizant that states may need a longer performance period – beyond the initial grant period – to establish a multi-payer delivery model that qualifies as an APM. Many states experienced delays with their APM decision-making (often to align with other state and federal reform efforts such as CPC+) that has shortened the implementation and evaluation period. Despite these challenges, a number of states have already started to align multi-payer models. Ohio and New York are currently focused on aligning SIM initiatives with CPC+. Starting in January 2018, Ohio will allow Medicare CPC+ practices to participate in the state’s multi-payer PCMH initiative. Additionally, all payers participating in Ohio’s SIM applied to participate in the CPC+ initiative. Likewise, New York encouraged plans participating in the state’s Advanced Primary Care Model to apply for participation in CPC+.

**Trinity Health urges CMS to support flexible and fair APMs – structured around total cost of care – that incent change in the delivery of better health, better care and lower costs, recognize the significant business investments needed to support these new models, and do not prematurely push providers toward risk models.** In designing any ongoing SIM initiative, CMS should prioritize and enable the alignment of federal and state – as well as commercial – efforts. CMS, for example, should consider SIM applications in concert with Medicaid and other waiver applications to further advance this movement toward health system transformation. Future SIM efforts should ensure participating states understand what is working within currently funded states and prioritize those successes in order to make payment model decisions. **CMS should consider working with states to create a “floor” for APMs by setting basic parameters for design features – Such as shared savings – methods of patient attribution, use of core quality measure sets, and assessment of outcomes. This would promote common APM features across states, easing provider and other stakeholders’ ability to engage in multiple APM efforts and to transfer learnings across settings and communities.**

### **Conclusion**

The SIM initiative has been a catalyst for stakeholder engagement around transformation; structuring payment Policy to support transformation; and innovative approaches to community engagement and population health efforts. More can be done to support transformation. CMS should capture and promote learnings from current SIM efforts before expanding to additional states. Current SIM states should be permitted to expand the duration of testing in light of the shifting landscape. CMS should focus on the development of nationally recognized core quality metrics, an APM reporting tool, and standardized data collection. Going forward, CMS should negotiate APM models at the onset of SIM awards, and include consideration of relevant requests for Medicaid, Medicare, and Section 1332 waivers. SIM progress should be measured and shared publicly. There should be an expectation of transparent data reporting, infrastructure development for data collection and analytics, and adoption of uniform quality metrics. States should be encouraged to use their unique position as health care incubators to further population health





STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

October 28, 2016

Mr. Andrew Slavitt  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Maryland Department of Health and Mental Hygiene Comments on *State Innovation Model Concepts* Request for Information**

Dear Mr. Slavitt:

The Maryland Department of Health and Mental Hygiene (“the Department”) submits these comments and recommendations regarding the Centers for Medicare and Medicaid Services’ (CMS) “Request for Information on State Innovation Model Concepts”. The Department recognizes the support that CMS has provided to the states as part of its ongoing State Innovation Models (SIM) Initiative and welcomes more collaborative efforts in the future.

All told, the SIM Initiative has provided about \$960 million to 38 states, territories, and the District of Columbia spread through two rounds of awards. The Department has been a participant in Round One and Round Two of SIM, and the opportunities afforded by the grant have been a critical source of support to Maryland as the Department has worked to develop the State’s health system transformation vision.

The Department offers input on four aspects regarding the SIM Initiative.

- First, the Department agrees with CMS’ emphasis on states acting as incubators and testing grounds for innovative payment and service delivery models and further encourages CMS to ensure that SIM Initiative opportunities down the road are made available to SIM design states, as well as SIM test states, in order to spur transformation.

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- Second, the Department would like to highlight its efforts in population health planning as a means to inform CMS' thinking on population health initiatives that could be funded in a future opportunity.
- ☐ Third, the Department views the criminal justice re-entry population as a key population for additional interventions in a future round of funding.
- ☐ Fourth, the Department asks that CMS consider comments submitted by the National Academy for State Health Policy (NASHP) to the Department of Labor Notice of Proposed Rulemaking # EBSA-2016-0010 on the *Gobeille v. Liberty Mutual Insurance Co.* decision, which could significantly and adversely affect the contributions of All-Payer Claims Databases to SIM and other health system transformation initiatives.

A more detailed description of comments and recommendations in each of the aforementioned areas is outlined below.

### **The States Are a Vital Source of Innovative Health Care Payment and Service Delivery Models**

The SIM Initiative began with the goal of providing state governments with a unique opportunity to design and test innovative health care payment and service delivery models. This intent acknowledged the notion that states must function as a locus of change because much of health system transformation occurs at the state and community levels. Therefore, the Department encourages CMS to continue its support of states through future SIM funding opportunities or technical assistance opportunities.

The State of Maryland has fully embraced the spirit of innovation and participated in both Round One and Round Two of the SIM Initiative. In the most recent round of design funding, the Department has been developing a framework for an integrated delivery network (IDN) targeted specifically for the dually-eligible Medicaid/Medicare population, creating a population health framework that will prioritize and promote population health over the long term, and developing a strategy to bring nursing facilities into our Health Information Exchange (HIE). These efforts have been critical components of our overall health system transformation, working in tandem with the All-Payer Model.

The Department requests that CMS continue to sustain its support for both SIM design and test states. The SIM Initiative opportunities are critically important for design states moving forward. SIM funding and technical support allows states to develop innovative plans that reflect their communities, and offers resources to support the engagement of diverse groups of stakeholders, including payers, providers, and consumers. The support afforded through the SIM Initiative is a crucial component for states such as Maryland to accomplish these goals. In that light, other SIM Initiative offerings for both design and test states in the future could form a key part of

achieving the ultimate goals of improved health system performance, increased quality of care, and decreased expenditures.

### **Measuring and Improving Population Health to Complement Payment and Delivery System Reform**

CMS has expressed interest in delivery and payment efforts with an explicit focus on states assuming accountability for population health outcomes and strategies to integrate population health improvement into core delivery system reforms. The Department has begun developing a population health strategy to play a role in the State's health transformation efforts and the SIM design monies have been instrumental in this process. Under Maryland's All-Payer Model, both the financial incentives and the delivery system have shifted toward value-based care. In response to these trends, Maryland has begun to reformulate its system of population health measurement to better reflect this emerging transformation.

First, the State is focusing on a small set of measures that address broad indicators of health of interest to the State, which include chronic disease, risk factors associated with chronic illness, and hospital utilization. What is unique about the State's efforts to map out measures over the near, short, and long-term is that the measures would be applied across entire population geographies or population sub-groups, instead of only a health care provider or health plan. This will create true accountability for an entire population's health and is intended to promote partnerships, prevention, and public health.

Second, the State is working toward a population health plan to sustain population health improvement and promote continued public-private collaboration in Maryland in order to complement payment reform efforts. The goal of the plan is to provide a framework of priority areas and strategies to address the most pressing health needs in the State alongside options to reinforce population health activities in the future of health transformation in Maryland.

### **Supporting Re-Entry of the Criminal Justice Population**

The Department appreciates the opportunity to comment on specific care interventions for which additional, state-based evidence is required. Developing comprehensive systems of care for the criminal justice population is an example of a care intervention that could benefit from additional testing across multiple states or in a single state.

The expansion of Medicaid eligibility to adults with incomes up to 138 percent of the federal poverty level (FPL) was designed to greatly increase access to coverage and services for low-income adults. In particular, the expansion allows for coverage of most people recently released from jails and prisons. Access to care can improve health outcomes and reduce recidivism in this population. About 1 in 36 adults in the United States were under some form of correctional supervision at year end 2014, and in Maryland, 1 in 42. The importance of making the health

insurance coverage connection for individuals with criminal justice involvement cannot be overstated:

- ☐ The incarcerated population is disproportionately comprised of people of color, increasing health disparities;
- ☐ Individuals in prison or jail are more likely to suffer from chronic and infectious diseases;
- ☐ The criminal justice population as a whole is more likely to be low income and uninsured; and
- ☐ Individuals with criminal justice involvement have a higher prevalence of mental health and substance use disorders than the rest of the population.

To date, over 270,000 individuals have enrolled in Maryland Medicaid under the adult expansion, but it is believed that the State is missing a significant portion of individuals leaving prisons and jails. Based on data from the Department of Public Safety and Correctional Services, 12,000 of Maryland's 21,000 prison inmates are designated at any given time as chronically-ill with behavioral problems, diabetes, HIV, asthma, high blood pressure, and other conditions.

Similar to many other states, Maryland has struggled with developing a sustainable solution to enrolling individuals and connecting them to health and social services upon release. It is for this reason that we are in active discussions with CMS to create through an 1115 waiver a presumptive eligibility option for individuals leaving correctional settings. Beyond eligibility, we also see opportunity to build interventions to serve this population, and a SIM initiative to support the design and test of such a model would be a wise use of resources.

### **Encourage Full Participation in All-Payer Claims Database s to Be Leveraged in SIM**

The Department requests that CMS consider the comments submitted by the National Academy for State Health Policy (NASHP) and the All-Payer Claims Database Council (APCD Council) in response to the Department of Labor's (DOL) request for public comment on "those conforming amendments and the proposed annual reporting requirements for plans that provide group health benefits, including the new Schedule J, in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016)."

The *Gobeille* decision – which struck down the requirement that self-funded employee health plans had to report their data to statewide all-payer claims databases (APCD) – was a devastating blow to state APCDs, which were developed to serve as a statewide, central repository of health care claims and enrollment data from multiple payer sources. The loss of this particular dataset has troublesome implications to Maryland's health system transformation efforts because self-funded employee health plans comprise 34 percent of the State's potential APCD data collection

efforts.<sup>1</sup> This effectively created an information blind spot, one that prevents Maryland's APCD from providing the State with the accurate information it needs to make correct decisions and Analyses regarding its efforts. Other states that also operate their own APCDs and participate in the SIM Initiative face this barrier as well.

NASHP and the APCD Council have submitted a joint comment and proposal<sup>2</sup> to the DOL, recommending three key points: (1) adopting the Common Data Layout, which is a standardized set of health care claims data; (2) mandating that any DOL requirement for plans that submit health care claims data be tied to its proposed Schedule J; and (3) implementing a DOL pilot program to collect health care claims data in cooperation with state APCDs. The NASHP/APCD Council submission avoids the legal pitfalls that proved to be fatal in *Gobeille*, while also ensuring APCDs are able to fully meet their original goals.

The Department supports the NASHP/APCD Council's comments above and urges CMS to support them as well. The magnitude of the situation cannot be overstated, for without prompt action, *Gobeille* will continue to significantly negate the progress that states make through its partnership with CMS, along with any other policy efforts that states make in their own attempts to improve health care quality and access.

Thank you for considering our comments and recommendations regarding the State Innovation Model Initiative. Please contact Aaron Larrimore at [aaron.larrimore@maryland.gov](mailto:aaron.larrimore@maryland.gov) or 410-767-5058 with any questions on our submission.

Sincerely,  
Shannon M. McMahon  
Deputy Secretary for Health Care Financing

<sup>1</sup> This could have even larger ripple effects nationwide, as up to 63 percent of all workers in the country are currently covered through self-funded employer health insurance plans. *2015 Employer Health Benefits Survey*, The Kaiser Family Foundation (Sept. 22, 2015), <http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>.<sup>2</sup> National Academy for State Health Policy (NASHP), in collaboration with National Association of Health Data Organizations (NAHDO), and the APCD Council. Comments on Department of Labor Notice of Proposed Rulemaking Docket # EBSA-2016-0010; RIN 1210-AB63. September 20, 2016. [http://www.nashp.org/wp-content/uploads/2016/10/CA\\_-Final\\_-NASHP-Comments-and-Proposal-to-DOL.pdf](http://www.nashp.org/wp-content/uploads/2016/10/CA_-Final_-NASHP-Comments-and-Proposal-to-DOL.pdf)

## SPECTRUMHEALT

Spectrum Health System  
100 Michigan Street NE  
Grand Rapids, MI 49503-2560

Re: Center for Medicare and Medicaid Innovation Request for Information on State Innovation Concepts

***Via Electronic Submission ([SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov))***

To Whom It May Concern:

Spectrum Health appreciates the opportunity to provide input on the Request for Information (RFI) on State Innovation Model (SIM) Concepts. We appreciate the Centers for Medicare and Medicaid Services (CMS) issuing this important RFI, which responds to our earlier comments on the Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS- 5517-P). **It is critical CMS offer a more meaningful glide path for current SIMs e.g., Michigan Primary Care Transformation Project (MiPCT) to qualify under the Advanced Alternative Payment Model (APM) track of the Quality Payment Program (QPP). Clear recognition and acknowledgement of these models under the APM track will allow their important capabilities and savings to continue, and help ensure that employed providers of large health care systems can appropriately build upon previous SIM participation efforts.**

Spectrum Health is the largest non-profit health care system in Western Michigan, with 12 hospitals, 170 ambulatory and service sites and more than 1,938 licensed beds system wide. Additionally, the system includes a 1,200-provider medical group.

**Spectrum Health supports the agency's efforts to support a state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation. However, it is critically important that this new model focus on alignment.** Too many new or different participation requirements during initial multi-payer model years will inappropriately place tremendous burden on those large systems that have already built specific reporting tools, trained staff, and educated front line providers for successful participation in existing state-based models. Alignment with the appropriate phase-in time e.g., minimum of 12 months, will prevent health care systems from having to drastically reconfigure or create new reporting/attestation processes to meaningfully participate. These reconfigurations, if not done in a thoughtful and time appropriate manner can have unintended consequences on patient access to high quality health care.

Below outlines in more detail specific areas CMS must consider as it explores the development a new multi-payer models with Medicare, Medicaid, CHIP, and third party payer participation. Overall, states should have multiple opportunities, within appropriate timeframes, to best align with existing Medicare models. CMS should work to identify multi-payer models that build on

## SPECTRUM HEALT

past efforts, and allow for economies of scale with regard to reporting, data collection and submission.

### Factors Essential to Success

- *Physician Compensation Models:* Health care systems across the country are focused on redesigning and deploying new physician compensation models. CMS must work with health care systems to best identify how development of its value-based payment models can support or align with these efforts.
- *Quality Measure Alignment:* Different payers have different quality metrics. Currently, Spectrum Health ambulatory providers are managing the collection and reporting of over 53 quality measures. It is difficult to focus on improvement when we are measuring diseases differently. CMS must further strengthen its past efforts to not only align measurement around the top chronic conditions, but ensure use of standard measure sets across payers.
- *Structured Data:* Health care data needs to be submitted in a standard way. Currently, our analytics department creates different reports for the same measure in order to satisfy varying submission criteria. This is not productive. Medicare, Medicaid, and private payers should support the use of data standards that help reduce the unnecessary reporting burden on health care systems. Alignment around structured data would allow health care systems like Spectrum Health to refocus staff efforts on quality improvement, rather than the creation of slightly different quality reports for compliance.
- *Patient Eligibility:* Identifying eligible patients for varying, yet similar payer programs can be challenging. We are currently required to run differing reports to see which patients may be eligible. Patient assignment is not uniform across different payer programs, and the format that our health care system receives this information in is also not uniform. CMS, along with other payers, should inform health care systems up front who their eligible patients are, and make patient assignment more easily interpretable.
- *Care Management:* Health care systems, on behalf of providers, need good data from payers on risk stratification to appropriately assign care management resources across their patient pool to ensure rendering of these services when appropriate. To date, Spectrum Health has been challenged by missing information from payers on whether an attributed patient is at risk. In addition, we recommend care management services be payer agnostic, regardless of coverage to ensure all patients receive the same-level of care.
- *Preparing for MACRA Advanced Alternative Payment Models (APMs):* As health care systems evaluate and prepare for participation in Advanced APMs, the inclusion of

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Medicaid will require a larger focus on addressing social determinants of health compared to other payers, e.g., transportation, housing stability, substance abuse, etc. It is important that CMS work with the states to provide health care systems with data about the populations its providers will care for. Access to this data in advance will improve how our System collectively cares for these patients.

- *Recruitment & Training:* Health care systems need time to recruit and onboard health workers to best participate and comply with new multi-payer payment models. CMS, in partnership with private payers, will need to offer targeted training materials and webinars for health care systems, specifically care managers, so that they can best address gaps, and identify concrete opportunities for how best to work as an allied health team. Standardized training made available through the CMS website or other easy to access modalities would also be very useful in preparing for new multi-payer APMs.
- *Population Health Analytics:* Electronic Health Record vendors have developed and continue to enhance population health analysis tools. It is important to note that the ability to purchase these tools, implement them, and use them in a timely fashion for managing a large patient population requires at least 12 to 24 months. CMS must allow enough time between the announcement of a new multi-payer model and required participation to allow for adoption and use of the aforementioned population analytics tools.
- *Governance Structure:* Harmonizing a governance structure post hospital and medical group mergers should be taken into consideration as CMS explores the development of new multi-payer models. The integration of EHRs, workflow processes, and culture will be essential for success. Adequate ramp up time will be needed, as well as allowed for hardships for those providers that change ownership during a performance period.
- *Health Information Exchange (HIE):* Health care systems are challenged with the critical questions regarding how best to manage, synthesize, evaluate and report comprehensive health care quality data. Timely data is essential if it is to be actionable for care improvement. HIEs, unlike All-Payer Claims Databases (APCDs), provide access to more timely data that provides more actionable information to our care teams. As health care systems evaluate participation in HIEs, it is important to understand up front if the HIE adheres with Certified EHR Technology (CEHRT) data transmission standards. HIEs, regardless if local, regional, or national, should move health care systems to uniform standards. We urge CMS work to help existing HIEs comply with federal data transmission and standardization processes as outlined under CEHRT. Many systems participate in payer initiatives to receive access to HIE data. Spectrum Health urges CMS to make Medicare claims data more readily available to all formal HIEs that request it. This would afford health care systems access to almost 80 percent of their patients'



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claims. How support a better health information exchange; great way to support this. All information is set; Don't get claims from all of our payers

- *Data Availability:* Health care systems and their providers continue to be challenged in their ability to set appropriate spending benchmarks for better managing the cost of care. While All-Payer Claims Databases aim to address this challenge, these databases often have incomplete or old data, which makes the information derived less actionable. Access to more robust data, specifically paid claims data, would allow providers to determine appropriate spending benchmarks. The CMS Qualified Entity (QE) Program (also known as the Medicare Data Sharing for Performance Measurement Program) is an opportunity for organizations to receive Medicare claims data under Parts A, B, and D for use in evaluating provider performance. However, current program requirements still limit the ease by which regional health collaboratives and other stakeholders can gain access. We urge CMS to more readily provide paid Medicare claims data to health care systems and regional collaborative so that we can better focus our efforts on how best to bend the cost curve and improve quality care.
- *Transparent & Standardized Payments:* Standardized payments from payers would also be advantageous in a multi-payer model. Multi-payer models are voluntary, however, CMS should require that those plans that do participate agree to standardized quality measures, reporting, and payments. For example, the Comprehensive Primary Care Plus (CPC+) Initiative requires payers to only align payments, quality measures, and other key components versus mirroring verbatim Medicare's approach to these tenets. Only requiring alignment, versus mirroring adds complexity to providers' financial and care processes.
- *Alignment with CPC+:* Any future multi-payer payment models focused on primary care should strive to align with CPC+. This alignment would enable primary care providers treating multiple care demographics to better standardize care processes that truly benefit patient outcomes.

Thank you for consideration of our comments. We look forward to working with CMS to help reduce duplication in our collective efforts to improve access to high quality health care for all patients regardless of payer or program. Should you have any questions regarding these comments or if you would like additional information, please contact Jennifer Meeks, Clinical Regulatory Affairs Principal for Spectrum Health, at [Jennifer.Meeks@spectrumhealth.org](mailto:Jennifer.Meeks@spectrumhealth.org).

Sincerely,

Ronald J. Knfujs  
Senior Vice President/ Chief Financial Officer

October 28, 2016

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
US Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Dear Administrator Slavitt:

### **Request For Information on State Innovation Model Concepts**

Thank you for the opportunity to provide comment to CMS on the concept and future of the State Innovation Model (SIM) initiative, a significant and important project of the Innovation Center. State Health and Value Strategies (SHVS), a national program of the Robert Wood Johnson Foundation headquartered at the Woodrow Wilson School at Princeton University, has worked with states for several years on the goals of payment and delivery system transformation. Recognizing the need for such efforts in every state, SHVS has focused much of its work on those states that did not receive SIM funding – providing technical assistance directly to states so they can achieve their transformation goals.

SIM has been a critical part of the innovation effort for many states. The opportunity for funding to support research, analysis and facilitated conversations with partners across sectors jumpstarted efforts to achieve new models across the country. The recent release of the final rule for the Quality Payment Program (QPP) under MACRA represents the next phase in the national effort to transform our health system. The opportunity for states to align their efforts with QPP – specifically through the “Other Payer” Alternative Payment Model (APM) threshold test for payment year 2021 – is the kind of federal partnership in payment transformation that so many states sought.

However, a number of open questions remain for states, and those questions likely differ based on a state’s participation in SIM Round 1 and 2 test projects. For states that are currently participating in a SIM Testing project, the first question is whether the intense effort undertaken by the state through SIM will actually meet the tests laid out by the QPP for Other Payer APM qualification. For states that have not received a SIM Testing grant, what support would be available to achieve the alignment? A continuation of SIM or a model of support like SIM will be critical for states who are starting transformation efforts at this point.

States are clearly interested in achieving the goal of transforming the payment and delivery system. When SHVS solicited non-SIM Test states for their interest in modest levels of technical assistance to promote a greater reliance on value in their health care system, 18 states responded proposing a wide range of projects. There is substantial interest, and as states start to understand QPP and how it could lead to a greater adoption of value-based models, that interest will grow. The first step for the states that are not yet pursuing payment and delivery system transformation is a clear understanding of the opportunity that QPP presents. Coordinated communication from SIM, CMCS, and CMMI will be of critical importance, and external partners, including advocates and philanthropic ventures, should be leveraged to attain greater penetration of the message of QPP.

One opportunity for the federal government to take on a proactive role in support of state innovation is information-sharing with states. If CMS could share with states the list of Qualifying Providers (QPs) in APMs, states could work with those vanguard providers to achieve greater transformation more quickly. Showing the outcomes of QPP on a state basis would also help to bolster support for payment transformation in states. For example, the number or percentage of providers receiving MIPS payments, and the value of those payments, would be important information that could support further state efforts.

QPP is a clear opportunity for alignment between Medicare and state innovation efforts. SIM, in either its previous model or one that focuses more directly on how states can leverage and align with QPP, remains a necessary activity to engage and support state efforts. A lack of financial and staff resources, a focus on rule compliance before transformation efforts, and continued provider pushback are still preventing states from achieving their goals in transforming their payment and delivery system.

For any clarifications on these comments, please do not hesitate to contact us.

Sincerely,

Heather Howard  
Director  
[heatherh@princeton.edu](mailto:heatherh@princeton.edu)

Daniel Meuse  
Deputy Director  
[dmeuse@princeton.edu](mailto:dmeuse@princeton.edu)



October 28, 2016

Dr. Patrick Conway  
Deputy Administrator for Innovation & Quality  
Centers for Medicare and Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244  
Submitted electronically to [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

**NAMD Comments in Response to Request for Information (RFI) on State Innovation Model Concepts**

Dear Dr. Conway:

On behalf of the nation's Medicaid Directors, thank you for the opportunity to respond on the request for information (RFI) on State Innovation Model Concepts.

The National Association of Medicaid Directors (NAMD) is a bipartisan organization which represents Medicaid Directors in the 50 states, the District of Columbia, and the territories. Medicaid programs are often the largest insurers in a state, with responsibility to provide coverage for the sickest, frailest and most complex and costly patients in the country. To best serve these populations and ensure the sustainability of the program, Medicaid Directors are working to reorient the health care system to achieve better services, better health and lower costs. In addition, many Medicaid Directors are playing a key role in driving statewide, multi-payer transformation.

Medicaid Directors greatly appreciate the Center for Medicare and Medicaid Innovation's (CMMI) work to enhance the state investment in health system transformation through the current State Innovation Model (SIM) initiative. We are also pleased that this state-led innovation is beginning to reverse the trajectory of health care and ballooning cost growth. The recent evaluation of the six original SIM Model Test states identified early signs of this emerging trend.<sup>1</sup> It also provides further evidence that states are ideally positioned to transform health care in the U.S. from a volume-based to a value-based system.

As indicated in the CMMI evaluation and earlier NAMD publications, this success is not instantaneous. It takes time and sustained investment for states to build the complex infrastructure necessary to support reform, including in the original SIM Testing States. More specifically, this infrastructure includes developing data analytic tools and systems to support providers and managed care organizations, building a quality measurement and improvement framework, creating practice transformation

<sup>1</sup>"State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report." RTI International. August 2016.  
<https://downloads.cms.gov/files/cmmi/sim-round1-secondannualrpt.pdf>

supports, and acquiring the necessary staff and contractor support with the appropriate expertise. Some states have made significant progress in building this infrastructure, but there is substantial work still to be done – from the most advanced states to those just beginning this journey. **As a result, Medicaid Directors strongly support a next generation SIM initiative to continue building state capacity to lead the movement to a value-based health care system.**

To sustain the transformation under current and future generations of SIM, CMS must re-envision its relationship with states. As co-financers of the Medicaid program, states are uniquely positioned as partners with CMS – rather than stakeholders – in setting a course for a value-driven health care system. As such, there should be a formal structure or defined role for state input in policy planning, implementation and evaluation processes for health system transformation.

We agree that an evolved SIM initiative should more explicitly seek to promote alignment in strategies and purpose between Medicare and Medicaid value-based purchasing models. Many states – including SIM participants, as well as states that have not engaged in SIM to date – are leading complex and dynamic reforms in parallel to Medicare’s movement towards value in the health care system. Even as states and federal policymakers work on separate tracks to transform the nation’s health care system, there is an opportunity to multiply the success of our mutual work by incorporating Medicaid’s state-based models and lessons learned into the fabric of federal value-based purchasing initiatives. At the same time, misalignment results in duplication and confusion for providers, which could impact the success of our collective work.

CMMI has suggested using the Medicare Access and CHIP Reauthorization Act’s (MACRA) Advanced APM framework as the overarching guide to achieve Medicare/Medicaid VBP alignment under a future SIM initiative. Although MACRA’s payment reforms are still in the pre-implementation stage, we generally agree with this framework for alignment. Still, given that the experience with MACRA will only begin to emerge in the coming years, we believe it is prudent for CMMI to engage in additional consultation with states before the federal agency moves ahead with a next generation SIM initiative that is linked to MACRA. Similarly, we request that CMMI clearly articulate the linkages between the Advanced APM framework and Medicaid models developed under CPC+, the current SIM program and applicable CMMI models that may still be forthcoming.

**In addition, for this MACRA framework to be successful, it must also include a clear pathway to incorporate state-led models.** Such a pathway should guide broad alignment with the Advanced APM framework while still accommodating unique requirements and characteristics of the Medicaid program. In particular, this pathway should allow states to identify (in collaboration with CMS) Advanced APMs in their Medicaid programs that are considered Other Payer Advanced APMs. We are pleased that the final MACRA regulation indicates a willingness to consider such a deeming pathway.

Finally, we ask that the next generation SIM initiative promote solutions to mitigate the barrier that a federally mandated prospective payment system (PPS) creates for many states to comprehensively transform the health care system. Federally qualified health centers (FQHCs)/rural health clinics (RHCs) provide critical access to services for Medicaid beneficiaries; however, the statutory-construct of the

mandated PPS limits states' ability to use the full range of value-based purchasing strategies in this care delivery setting, including to incorporate risk as envisioned under MACRA's Advanced APM framework. In addition, these safety-net providers are often excluded from federally-led multi-payer models, such as the Comprehensive Primary Care Plus (CPC+) program. Segmenting these providers hinders administrative simplification, as well as consistent application of metrics and payment strategies across all payers and providers. The PPS and this segmentation is a major challenge for many state Medicaid programs as they seek to align APMs across payers and providers, and is a barrier that CMMI and its federal partners within HHS could begin to address through the next generation of the SIM initiative.

Once again, we would like to underscore our appreciation for the support CMMI has dedicated thus far to state-led transformation through the existing SIM initiative. We strongly encourage CMMI to continue its support for states to move the health care system from volume to value. Thank you for the opportunity to comment on this RFI, and we look forward to ongoing engagement with you and your team going forward.

Sincerely,

Thomas J. Betlach  
Arizona Health Care Cost  
Containment System Director  
State of Arizona  
President, NAMD

John B. McCarthy  
Director  
Ohio Department of Medicaid  
State of Ohio  
Vice-President, NAMD

## NAMD Comments on CMMI Request for Information on State Innovation Model Concepts

### SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

- 1. What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?**

Medicaid Directors across the country are committed to transforming the health care system to improve quality and deliver value. A March 2016 NAMD & Bailit Health Purchasing report found that the majority of the 34 states surveyed were planning for or implementing value-based purchasing strategies.<sup>2</sup> States recognize that the predominant approach of fee-for-service payment to providers often fails to deliver high-quality and cost effective care for beneficiaries. States also recognize that multi-payer collaboration can help accelerate this work. As a result, Medicaid Directors are very interested in engaging with CMMI through the next generation of SIM to continue advancing health system transformation across payers.

Specifically, state Medicaid Directors believe that alignment in strategies and purpose between Medicare and Medicaid value-based purchasing models will help accelerate our movement to value-driven health care system. At this early stage of MACRA implementation, states also broadly agree that the MACRA Advanced APM framework (which requires the use of certified EHR technology [CEHRT], linkage of payments to quality, and shared risk with providers) can be a tool to move towards this goal, but only if it includes a pathway for state adaptation and design of Medicaid Advanced APMs. We appreciate that the final MACRA regulation indicates a willingness to consider this pathway and ask that CMMI collaborate with states to solidify such an approach before linking MACRA to a future SIM initiative.

Specifically, this pathway should permit state adaptation by:

- *Allowing states to identify – in collaboration with CMS – those advanced APMs in their programs that are considered Other Payer Advanced APMs.* States should be able to submit for review and approval those models that reflect unique Medicaid considerations but broadly align with the MACRA principles of CEHRT use, linking payment to quality, and assuming risk. State Medicaid programs serve a complex and diverse population – from the elderly and disabled needing long-term services and supports, to adults with substance use disorders,

<sup>2</sup> “The Role of State Medicaid Programs in Improving the Value of the Health Care System.” National Association of Medicaid Directors, Bailit Health Purchasing. March 22, 2016. [http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD\\_Bailit-Health\\_Value-Based-Purchasing-in-Medicaid.pdf](http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf).

and children with special health care needs. As such, state-led APMs are designed to meet the needs of this diverse population and also reflect the states' cultural diversity, budget parameters, administrative infrastructures, stakeholders, provider capacity, and a host of other factors.

- *Creating clear linkages with Medicaid models developed under CPC+ and the APMs developed under the current SIM program.* The next generation SIM initiative and the Advanced APM program must build on – not disrupt – the work that many states already have underway to promote multi-payer alignment around APMs. Doing so allows states to leverage current momentum and multi-payer buy-in. At a minimum, a clear articulation of the link between existing federal initiatives (CPC+, SIM, etc.) and the Advanced APM program is needed.

Until a deeming pathway is created for state-led models that resolves these two issues, it would be inappropriate for the Advanced APM framework to be the basis for Medicaid/Medicare alignment in APMs in the next phase of SIM.

In addition, while there is significant state interest in multi-payer models that include Medicare participation, practically speaking it is unclear the extent to which Medicare can adapt to participate in state-led models. The first SIM opportunity was designed with the understanding that Medicare would engage in state models. However, this did not come to fruition, disrupting state planning for multi-payer transformation. This prior experience raises considerable concern as states consider future initiatives. CMS could address this concern by offering a more detailed construct through which Medicare would be a part of a state's APM, including concrete examples of regulatory and administrative modifications that Medicare can make to integrate with state-led models. This will help states plan their multi-payer initiatives and set goals that are appropriate for the program and participating payers.

- a. **What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?**

The primary challenge states face in driving value-based reform the health care delivery system and achieving all payer alignment is building the necessary infrastructure to design and carry out this transformation, given limited financial and staff resources. NAMD's 2015 Annual Operations Survey found that Medicaid Directors reported needing additional positions in 2016 to meet the demands of payment and delivery system reform.<sup>3</sup> States must use a limited number of staff to maintain the day-to-day operation of the program while simultaneously standing up these innovations. It is also a challenge to recruit and retain staff

<sup>3</sup> "State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors." National Association of Medicaid Directors. November 2015. [http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD\\_Bailit-november\\_2\\_2015.pdf](http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-november_2_2015.pdf).



with the right skill sets, considering that these individuals are in high demand in the private sector, which can offer higher pay. States also must build the resources and tools to underpin these reforms, such as practice transformation supports and data analytic systems. These data systems, in particular, are time consuming and resource intensive but foundational to all APMs.

Much like the current SIM program, CMMI can assist states by investing in the development of this infrastructure. SIM has enhanced existing state resources dedicated to this work and allowed grantees to build or acquire data analytic tools, practice transformation supports, and enhance its staff capacity to carry out this transformation.

While this infrastructure is the primary challenge for states, Medicare participation in multi-payer reforms is another hurdle states face. It is problematic for states that design and stand up a multi-payer innovation in the state, only to have Medicare go in a different direction or create a distinct approach to essentially achieve the same ends. This can disrupt current state efforts to achieve broad alignment across payers. CMMI can begin to remedy this through the next generation of the SIM initiative, through which Medicare participates in successful state-designed reforms, as well as by making states a partner in the design and development of Medicare APMs (see Section III below). As noted above, CMMI needs to be candid about the feasibility of such Medicare participation in state-designed reforms, and provide a framework that makes it explicit when that participation will occur.

The third key challenge facing states in the implementation of multi-payer transformation is the statutorily-required prospective payment system (PPS), which has impeded comprehensive transformation in many states. While FQHCs/RHCs provide critical access to care for Medicaid beneficiaries, the PPS limits states' ability to use the full range of value-based purchasing strategies in this care delivery setting, including to incorporate risk as envisioned under MACRA's Advanced APM framework. This separate payment system for FQHCs also can result in their exclusion from federally-led multi-payer models, such as CPC+. This prevents administrative simplification and consistent application of metrics across all payers and providers. CMMI should work with its federal partners to mitigate this barrier in the next generation of SIM. If no such solutions are possible under current law, we call on the Administration to articulate legislative solutions.

- b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?**

The success of multi-payer delivery system transformation is only possible when there is strong state leadership and buy-in of key partners in the state. In particular, Medicaid Directors have a crucial role in providing leadership for these comprehensive reforms, given Medicaid's role as a major payer in the state and its role as a key innovator, as well as the policy levers at its disposal. Directors are also well positioned to engage with other payers,

providers, consumers, and other entities to build a coherent direction and strategy for this complex work. Medicaid agency staff also bring an important and unique skillset to multi-payer reforms, especially around care coordination and practice facilitation. For example, one state found that Medicaid participation in a multi-payer field team enhanced practice transformation efforts and directly contributed to the shared savings achieved.

A future phase of SIM should empower the appropriate state leadership, including Medicaid Directors, in this work, and support their ability to engage stakeholders in multi-payer transformation. It should allow states to do this through the mechanisms and approaches that are most appropriate for that state and with the stakeholders best positioned to facilitate the needed transformation.

In addition, timely data and a robust data analytic infrastructure are foundational to the success of future state-led transformation. This data helps states design their transformation, establish total cost of care benchmarks, support providers and plans in coordinating care and delivering evidence-based interventions, and allows rapid cycle evaluation to take place. Ongoing federal support for the development of the state IT infrastructure is important.

Further, state access to timely Medicare data and the ability to leverage such data is essential to the success of state-led, multi-payer innovations – especially innovations that will include Medicare. There has been early progress in helping states access Medicare data, such as through the Financial Alignment Demonstrations and the Innovation Accelerator Program. However, many states still find it difficult to navigate the process for obtaining the data and have limited capacity to use this Medicare data to support delivery system and payment reform once they have secured it. This includes data from the Medicare Advantage program. Additional federal support is needed in this area to help states obtain Medicare data and use it effectively. This could include additional and ongoing technical assistance and training to help state staff obtain and apply the data, or state-to-state sharing about best practices for accessing this information.

**c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?**

The most prominent challenge for states is the lack of clear understanding from CMS around how existing state models and efforts fit into the MACRA Advanced APM framework, which is left unaddressed by the final regulation. State-led, multi-payer work is complex, and states have invested significant time and resources into the development of APMs and new delivery systems. But in order to align with the MACRA framework, and not lose ground, there should be clear pathways for Medicaid models that are generally consistent with this framework to be considered Other Payer Advanced APMs or be deemed as such. We appreciate that CMS considers such a pathway in its recent regulation, and encourage the agency to finalize this

component of the Advanced APM program. As noted above, states should be able to identify models – in collaboration with CMS – that reflect unique Medicaid considerations but broadly align with the MACRA principles of CEHRT use, linking payment to quality, and shared accountability. Without this alignment, MACRA threatens to impede progress and derail successful state-led innovations.

As part of this deeming pathway, CMS must ensure that state models developed under CPC+ or the current SIM grants are considered Advanced APMs. States have invested significant time and resources in these multi-payer models. The next generation of SIM should build on these multi-year initiatives, rather than disrupt this work.

State Medicaid programs also face unique challenges around the use of CEHRT, which is a key component of the Advanced APM framework. Certain key Medicaid providers, such as behavioral health and LTSS providers, have had a lower uptake of EHRs due to their exclusion from the federal EHR Incentive Program. In order to use the Advanced APM framework as the guidepost for Medicaid/Medicare value-based purchasing alignment, additional focus is needed on this issue. In particular, CMS should build on the steps it has already taken to strengthen the investment in the HIT infrastructure for these key Medicaid providers.

Similarly, to be successful in Advanced APMs, providers will need to effectively share information and coordinate care through the use of health information exchange (HIE). However, federal limitations around substance use disorder data sharing (42 CFR Part 2) are a barrier to the most effective use of HIE to improve care in emerging delivery models. While the Substance Abuse and Mental Health Services Administration (SAMHSA) released a notice of proposed rulemaking on 42 CFR Part 2, the proposed changes do not sufficiently accommodate the movement to rapid and comprehensive communication between providers through HIE. Therefore, we urge CMS to continue to work with its federal partners at SAMHSA to facilitate – to the maximum extent possible – substance use disorder data sharing in new care delivery models, which broadly align with the Advanced APM framework. NAMD believes this must be a priority for the agencies in order to accelerate the movement to value-based purchasing.

Finally, Medicaid Directors are concerned that new federal regulations governing the Medicaid program may limit states' ability to transition to Advanced APMs over time. This includes potential conflicts between CMS's Medicaid managed care rule and the objectives of Advanced APMs. For example, the rule appears to prohibit differential payment based on value-based purchasing and sets specific requirements around encounter data, which may not be appropriate in a value-based environment. CMS should engage with states to identify and mitigate these barriers.

- d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement**

**from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?**

While the vast majority of states are planning for or implementing delivery system and payment reforms, they are at different stages in this process. As states move along this continuum of transformation, they require varying levels and types of support to advance this work. CMS resources and tools should be tailored to each state's work to date and particular infrastructure needs.

Across all stages of transformation, financial support can greatly enhance states' own investment and help states build the infrastructure needed to overhaul the health care system. States often have limited financial resources to do this work. The current investment under SIM has strengthened states' ability to engage stakeholders, enhance staff capacity and tap external expertise, design appropriate payment models, develop data analytic tools, and ultimately deploy multi-payer APMs. But sustained federal support is needed to further this work, particularly in states challenged by budget constraints. Transformation to a value-driven system is a multi-year – and often a decades-long – endeavor of iterative learning and advancement.

In addition to this financial investment, states need a clear pathway to engage with CMMI, Center for Medicaid and CHIP Services (CMCS), and the Medicare-Medicaid Coordination Office (MMCO) in an organized and cross-cutting way to effectively implement multi-payer reforms with Medicare participation (see Section III below). Currently, a state may work with CMMI to design a model for a period of months or years. Once CMMI approves a model, states then confront delays when seeking CMCS and MMCO sign-off on the necessary programmatic changes. In order for states to advance multi-payer reform, there needs to be an articulated pathway for these states to receive expedited approval of state plan amendments (SPAs), waivers, managed care contracts and rates related to such model. Likewise, CMS can help to advance this transformation by ensuring the HHS goals of value-based purchasing are understood and applied at all levels of the agency, including in the review of SPAs, waivers, and in the development of regulations and sub-regulatory guidance. Similarly, there should be a coordinated process to incorporate and engage other agencies within HHS, where necessary, including the Centers for Disease Control, SAMHSA, Administration for Community Living, Health Resources and Services Administration (HRSA), the Indian Health Service, and others.

To successfully implement multi-payer reforms with Medicare participation, states need a more deliberate partnership with CMS around the development of new federally-led APMs. Currently, states may invest significant time and resources to develop a multi-payer APM, only to be derailed by a new federally-led model or initiative. This is because there is not an appropriate structure for state engagement in this federal model development. States are not like other stakeholders; they are a co-financer of the program. The structures for state

engagement in the federal APM development process need to reflect this unique partnership role of states in administering state Medicaid programs and driving health system transformation.

Finally, CMMI could support multi-payer transformation by including a focus on children, as well as their families, in multi-payer APMs like CPC+. On average, children account for nearly half of all state Medicaid beneficiaries.<sup>4</sup> This makes it important for models aimed at supporting multi-payer transformation to have a focus on children and not exclude this key population simply because they are not included in the Medicare program.

- e. **If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?**

A new state-based model should provide a period of time for planning followed by a meaningful period of model deployment. As the evaluation of the initial SIM Testing States revealed, it takes time to thoughtfully design APMs, to deploy them, and to begin to see the impact. CMMI should look to this existing state experience when setting the timeframe for a new model. In general, we recommend the following timeframes:

- *Planning period.* The model should give states a 1-2 year period for model planning, which would vary based on the state's existing infrastructure for reform. During this planning period, states will need to conduct stakeholder engagement, deploy systems changes which may include a procurement process, and engage in complex state-federal negotiations around Medicare involvement or alignment. This type of planning period (or year zero) is found in many other new health care programs, such as the Certified Community Behavioral Health Clinic Demonstrations and certain state Delivery System Reform Incentive Pool Programs.
- *Performance period.* The performance period for a new SIM initiative should be 3-4 years, which would be the minimum time needed for states to deploy the multi-payer model, make necessary corrections, collect multiple years of data, and begin to identify the impact of the model over a period of time.

In addition, while these timeframes are needed to begin testing a model, it is important that sustained support is available for successful state-led models. We encourage CMS to identify pathways to continue its investment in successful state efforts.

<sup>4</sup> Kaiser Family Foundation. State Health Facts. "Monthly Child Enrollment in Medicaid and CHIP." July 2016. <http://kff.org/other/state-indicator/total-medicaid-and-chip-child-enrollment/>.

- f. **Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?**

Evaluation under this program needs to be state-specific and reflect the key health indicators identified by each state as most meaningful. For instance, one state and stakeholders may predominantly define success in terms of reducing health disparities. While in another state, hospital re-admissions or significant infant mortality may be the indicators of focus for its multi-payer APM. Allowing states to identify the indicators of success will ensure the reform is designed in a way that is meaningful for payers, consumers, and providers, and ultimately reflects the local health care marketplace.

In addition, CMS should evaluate the success of multi-payer models in terms of whether the reform is improving health outcomes relative to what preceded it, and whether there is a foundation for future improvement and success in that state. As we have noted throughout this letter, states must make a sustained investment in both time and resources to bring positive change to their health systems. Therefore, CMS can evaluate the success of models through an appraisal of whether the reform has created a framework for future success, as well as assessing real world implementation and measuring outcomes of reforms, which are also essential. This broader definition of success should be applied to delivery system reforms and take into account whether states are developing the infrastructure needed to put these foundational elements in place.

- g. **What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?**

In developing new models, CMS should design their core components to incentivize provider participation in state-led transformation, rather than pushing providers to choose between a Medicare-only model or a state-specific model. For example, the comprehensive primary care plus (CPC+) initiative initially precluded providers from participating in both Accountable Care Organizations (ACOs) and CPC+. This threatened a major disruption to numerous states using or advancing multi-payer ACO strategies by creating the unintended incentive for primary care providers to withdraw from the ACO models and participate in the new opportunity. This type of conflicting incentive can disrupt states that are far down the road with state-specific multi-payer models. To avoid this, CMS should identify ways to incentivize providers to participate in state-led models through its new Medicare opportunities, as well as meaningfully partner with states in the design of all federally-led models.

**2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.**

- a. **Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.**

State Medicaid programs are increasingly using delivery system and payment reform to hold providers and plans accountable for the health of the population they serve – from medical homes and episode-based payments to ACOs. While these innovations are being led by the Medicaid agency, there is increasingly alignment across payers in such APM strategies. Medicaid Directors are implementing these reforms in a manner that makes sense for their local marketplace, their culture and their environment. Therefore, there is variability in the type of model used and vehicle through which the model is implemented. But the most common categories of payment mechanisms, which states are using to link payment to population health are discussed below.

- *Additional payments that support delivery system reform.* In this approach, providers (typically primary care providers) receive a per member per month (PMPM) payment for a wide variety of purposes in exchange for meeting performance expectations. The goal of this model is to support infrastructure for health care delivery transformation efforts or traditionally unreimbursed services (e.g., care management), which are aimed at improving population health outcomes. Typically, additional PMPM payment models are attached to Patient Centered Medical Home and Health Home delivery systems and usually the PMPM is designated for a particular activity.
- *Episode-based payments.* In this model, one provider is held accountable for the costs and quality of a defined and discrete set of services for a defined period of time. The goal of this model is to improve population health by bringing an increased focus on identifying and refining clinical pathways that produce more effective and efficient care, including through improved coordination of care for a patient across different providers. Generally, the episodes that are being pursued are acute or episodic in nature (e.g., acute exacerbation of asthma or tonsillectomy).
- *Population-based payments.* In these APMs, states often hold one or more providers accountable for spending targets that cover the vast majority of health care services to be delivered to a specific population. In other cases, states make capitated payments to a provider for the delivery of a specific set of services (i.e., primary care, primary care and other services, or for all services). The goal of these population-based payment models is to align the incentives of the payer, the provider and the patient to improve the overall quality of health care and manage the costs. Population-based payment models require a provider to take on responsibility for care it delivers, plus consider the costs of downstream care, resulting in a focus on prevention. In some, but not all cases,

population-based payment models are applied to ACOs. These providers work together to coordinate the care of a population and improve their outcomes.

Each of these APM strategies represent a fundamental shift from a fee-for-service system to a focus on population health. State Medicaid programs have identified a number of resources that MCOs and providers need to implement these models. This includes support for transforming health plan activities, as well as support for transforming the provider practice, such as through practice coaching, written resources, and other tools. Providers and MCOs also need access to timely clinical and claims data on the population they are accountable for serving.

In addition, Medicaid Directors recognize that some of the most common quality measures are often not the most meaningful when it comes to improving population health. States are exploring new measures of population health to incorporate into APMs, such as measures of housing, justice involvement, and school readiness. But generally, these efforts are in their early stages. In order to deploy these measures, states need access to and resources to link new data sources with Medicaid data. This includes data from other state agencies (i.e., public health and department of education) as well as local data sources (i.e., county information on justice involvement and education). Significant collaboration is needed across state agencies, local government, and private stakeholders to incorporate such metrics of population health into multi-payer transformations.

**b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?**

Rural and tribal providers are essential to Medicaid and multi-payer delivery system and payment reforms that are seeking to promote population health. These providers are often a key point of contact for individuals accessing the health care system and may serve as the care coordinator under certain models. Therefore, they play an essential role in linking individuals to other available services and supports, which begin to address the social determinants of health and improve health outcomes.

In addition, given the clear linkage between social services and health care, there is an opportunity to align measures across state agencies and programs to promote health system transformation. As previously mentioned, many of these innovative measures are examining the states' collective impact on social determinants of health. Alignment around these measures can help to ensure the state, providers, plans and other stakeholders towards the same goalposts that improve population health.



- c. **How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?**

Medicaid Directors have identified and are exploring numerous strategies to address attribution and population-level responsibility for providers in their existing APMs. Given the complexity and nuance of this work, under a statewide model, states are best positioned to design an approach and attribution method that reflects the landscape of urban providers that may have overlapping catchment areas.

**3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.**

- a. **To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?**

Both payers and providers require a significant amount of data within APMs, and states continue to invest in the systems necessary to make this data available to these entities. This includes Medicaid Management Information Systems, as well as systems outside of the Medicaid agency, such as all-payer claims databases. States recognize the need for timely data to design and administer an APM, including setting total cost of care benchmarks, as well as to help providers target interventions and coordinate care under APMs.

In addition, while a few states have integrated Medicare data into their programs and payment models, many states continue to face challenges in obtaining Medicare data, linking Medicaid-Medicare data, and using Medicare data effectively. We recognize that significant progress has been made in helping states access Medicare claims data, including through resources offered by the MMCO and the Innovation Accelerator Program. However, states point to significant opportunity to build upon current success and continue to share lessons learned. Medicare data is complex, and dedicated training and support for state staff may be needed as more states become positioned to use the Medicare data effectively. This includes for the purposes of establishing total cost of care targets, delivering actionable information to providers to enhance care delivery, and support other key components of a multi-payer APM. States may also benefit from learning from states that have successfully navigated the process of accessing Medicare data.

- b. **To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and total payment to health**

**outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?**

Depending on state data systems and the maturity of the HIT infrastructure, there is variability around the level of access states have to data to calculate quality measures and population health measures on a multi-payer basis. In particular, existing Medicaid administrative and claims-based systems do not provide adequate information about clinical outcomes, which many new payment and delivery system initiatives aim to track as part of their accountability structure. States are working to address some of these data issues by promoting HIT and interoperability, including through Medicaid waivers and demonstrations. But there are ongoing challenges in the uptake in this area, especially among key providers that were not included in the EHR Incentive Program.

Similarly, Medicaid Directors have faced barriers accessing and leveraging Medicare clinical data to inform quality and population health measures. CMS needs to continue supporting the HIT infrastructure that will make this possible, as well as identify pathways and supports to help state Medicaid agencies access and link this clinical data to their own. This will support the success of multi-payer APMs that include Medicare participation, as well as to support integration initiatives for dually eligible individuals.

At the same time, states are in the very early stages of linking data on social services and supports to health system transformation. For example, Washington State has an integrated client database, which supports the state's Medicaid initiatives by providing key information on beneficiaries, including data on homelessness and incarcerations. States are beginning to connect these data sources because states and commercial payers recognize the importance of social determinants of health to health outcomes. Linking these data sets is extremely complex and requires significant collaboration across state agencies and with local entities in order to measure justice involvement, housing status, education readiness, and other factors. It also requires significant staff capacity and overcoming other operational and systems challenges with connecting these data with health care claims information.

- c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?**

NAMD and its members continue to partner with CMS to support the objectives of transparency and data reporting to CMS, including through T-MSIS. For example, we are working with CMS on data governance principles for T-MSIS, in hopes of establishing a federal-state process to inform the immediate priorities for T-MSIS data quality improvement, as well as a process for state review of analyses from T-MSIS and strategic prioritization of products from T-MSIS. The federal and state partners hope to foster a mutual understanding of the ability of T-MSIS to support state-led, multi-payer innovation, and what the timeframes for

using this data in that manner. We look forward to continued partnership with CMS in this area.

**d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?**

States vary in their capacity and readiness to perform these calculations and link payment to outcome measures. As noted above, in part this work depends on the maturity of state IT systems, and the SIM program and enhanced federal matching funds have been a critical source of support in helping states build the necessary infrastructure to deploy models that link payment to health outcomes. Many other states are planning for such models and/or building infrastructure to be able to do this work and would benefit from ongoing financial support and sharing of best practices to accelerate these activities, including data aggregation.

**e. What support can CMS provide to improve states' access to reliable and timely data?**

CMS can support states' access to reliable data in the following ways:

- Through ongoing financial support for states to build the necessary IT systems and data analytic capacity;
- Using its available policy levers to promote the adoption of EHR technology among key Medicaid providers, including LTSS and behavioral health providers (see Question f, below);
- Continuing to work with its federal partners at SAMHSA to facilitate to the maximum extent possible substance use disorder data sharing in new care delivery models;
- Sharing best practices for data collection and quality improvement, as well as best practices for linking health care claims and encounter data with other state and local data;
- Building on existing success to help additional states access and use Medicare claims data in a more meaningful way, and by facilitating the availability of Medicare clinical data;
- Partnering with other federal agencies to facilitate state access to and use of other federal data on Medicaid participants, such as data the Centers for Disease Control and Prevention, the Indian Health Services, the Department of Veterans Affairs and others.

**f. How can CMS support improve access to and linkage with health outcomes measures data?**

As discussed above, there is great interest on the part of Medicaid agencies to use clinical performance and health outcomes in multi-payer APMs. However, in some cases, the

necessary EHR infrastructure to do this continues to develop, as there must be standardization and sufficient EHR uptake on the part of providers to link such data. For instance, there are notable gaps in statewide EHR networks among certain key Medicaid providers. This includes behavioral health providers and LTSS providers, which were excluded from the HITECH Act's EHR Incentive Program. States appreciate CMS's steps to facilitate the adoption of EHRs among these providers. And we encourage CMS to continue using its available policy levers to build on these efforts and facilitate EHR use among behavioral health and LTSS providers.

**g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?**

In recent years, state Medicaid agencies have increased their sophistication and use of data to support program integrity, and they continue to build on this work, including as part of multi-payer transformations. Last year, NAMD's Annual Operations Survey found that 60 percent of respondents were focused on implementing data analytic tools and systems to support program integrity efforts.<sup>5</sup> But state Medicaid agencies also continue to confront unique challenges in this area, such as improving the quality of encounter data and modernizing legacy data analytic systems. Ongoing work in this area will smooth states' ability to oversee claims and encounter data and track provider and plan performance, especially in the new paradigm of value-based purchasing.

**h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?**

The IT infrastructure available to state Medicaid agencies and states more broadly to use data to support transformation efforts varies significantly by state. For example, some states rely on legacy MMIS, which may have limited functionality to support transformation, while many other states are in various stages of modernizing their systems. Similarly, some states have a robust and well-developed HIE, while others have more limited ones. The same is true for EHR penetration. The relative maturity and spread of HIT means that states must leverage different approaches and strategies for using data in their transformation efforts.

Finally, the staff capacity to manage and maximize the IT systems, which is a key piece of the IT infrastructure, is generally a challenge for states. Widespread interest in data analytics across the health care sector means that these staff command high salaries in the private sector, making it difficult for states to recruit and retain these staff.

<sup>5</sup> "State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors." National Association of Medicaid Directors. November 2015. [http://medicaiddirectors.org/wp-content/uploads/2015/11/namd\\_4th\\_annual\\_operations\\_survey\\_report\\_-\\_november\\_2\\_2015.pdf](http://medicaiddirectors.org/wp-content/uploads/2015/11/namd_4th_annual_operations_survey_report_-_november_2_2015.pdf).

## **SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES**

- 1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically, we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).**

The fundamental nature of our health care delivery system requires that states tailor interventions to the needs of the state population. Variation is essential to the success of this work due to differences in state delivery constructs, provider landscapes, budget parameters, geographic features, and population health needs. For example, many state Medicaid agencies have been addressing access and use of immediate post-partum long acting reversible contraceptives (LARC). The interventions to improve the use of LARC differ significantly by state. One state may be unbundling LARC reimbursement from APR-DRGs, but another state may implement new managed care contract requirements around LARC. In another instance, many states are implementing initiatives to integrate physical and behavioral health care for those with behavioral health needs. These interventions differ by state significantly: from the use of telemedicine to connect individuals to specialty behavioral health treatment to incorporating behavioral health services under a comprehensive managed care contract. Standardization would remove the critical flexibility states need to meet the needs of their population.

- 2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?**

Given the differences between states and the health care landscapes, we are concerned this type of approach could minimize state flexibility to design an intervention and shape it to the state's needs. We anticipate limited, if any, interest among states for simply taking a model that has shown promise in one region to another without appropriate state adaptation. Instead, CMS should support states in adapting interventions to that individual state and supporting the state in evaluating its effectiveness.

- 3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.**

Rather than standardizing care interventions, CMMI should support states in tailoring interventions to address key populations and programmatic areas of focus for states. For example, NAMD's 2015 Annual Operations Survey identified individuals with behavioral

health needs as a major priority for states. It found that 92 percent of respondents were planning, implementing, or already implemented behavioral and physical health integration. CMMI could support states in this work by facilitating the state design of an intervention that makes sense for the population and program. Likewise, many states are driving innovation around individuals receiving long-term services and supports (LTSS).<sup>6</sup> Rather than spreading a one-size-fits-all intervention for this population, CMMI should support the state in designing care interventions that are tailored to this priority population.

**4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes, and what specific care interventions and data collection efforts are needed to address health disparities for these populations.**

States are using payment and delivery system transformations to reduce disparities in their state, including by addressing the social determinants of health that contribute to disparities. Medicaid programs, which are responsible for the health care of a state's most vulnerable populations, are leading the way through this innovation and forging closer partnerships with other state agencies and counties. States are designing these interventions to reduce disparities based on the state landscape and culture and needs of their diverse populations. These range from care coordination strategies for justice-involved populations to interventions focused on adverse childhood events.

CMS can support this work by removing any policy barriers to states' ability to link state-level data sources (such as 42 CFR Part 2) and by providing ongoing financial support for the development of state IT infrastructure. Similarly, CMS and its federal partners can help to facilitate this work by making available federal data on state residents that provides critical insight into health disparities and the social determinants of health, including data from HRSA, the Centers for Disease Control, and Indian Health Service, and others.

Additionally, we believe many more states are well-positioned – or could be with additional support – to mitigate the challenges experienced by individuals dually eligible for Medicare and Medicaid. States have a strong interest in working with CMS to advance coordinated care models and administrative alignment across the two programs. Many states wish to continue to improve upon their duals demonstration initiatives while others are looking to CMS to offer additional pathways to improve outcomes for beneficiaries. For example, this could include streamlined access to administrative flexibilities that allow states to leverage Medicare Advantage Special Needs Plans (including Dual Eligible SNPs) and Medicaid Managed Long Term Services and Supports programs. In addition, CMS could provide opportunities for states that rely on a fee-for-service delivery model by extending opportunities for sharing savings to them. Another model that some states are interested in is a Patient Centered Primary Care

<sup>6</sup> "State Medicaid Operations Survey: Fourth Annual Survey of Medicaid Directors." National Association of Medicaid Directors. November 2015. [http://medicaiddirectors.org/wp-content/uploads/2015/11/namd\\_4th\\_annual\\_operations\\_survey\\_report\\_-\\_november\\_2\\_2015.pdf](http://medicaiddirectors.org/wp-content/uploads/2015/11/namd_4th_annual_operations_survey_report_-_november_2_2015.pdf).

Home model that would allow states to integrate care for dually eligible individuals with disabilities. Finally, CMS should include a pathway in the next generation of SIM for state Medicaid programs to assume full responsibility for the Medicare portion of spending for dually eligible individuals.

### **SECTION III: STREAMLINED FEDERAL/STATE INTERACTION**

- 1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?**

State Medicaid programs have engaged with CMMI through a number of models and activities, most notably, the State Innovation Model (SIM) program. However, there is a critical need to improve state involvement in the design and creation of federally-led delivery system and payment reforms. Most importantly, this collaboration should be inculcated into the federal process for designing and implementing APMs. CMS' relationship with and engagement with states should be distinct from the relationship with the broader stakeholder community. States are a co-financer of this health care program, and model development, implementation and evaluation should occur with deliberate state partnership. This will help to align new CMMI models with state value-based purchasing initiatives and maximize our collective success.

In addition, this collaboration is needed to avoid conflicts between parallel federal and state transformation efforts. For example, CMMI's CPC+ model initially threatened the viability of state-led, multi-payer strategies focused on ACOs because it excluded CPC+ providers from participating in ACOs. This created a perverse incentive for primary care providers to withdraw from ACOs in favor of participating in CPC+. This type of conflict could be avoided through state partnership with CMMI in the design and deployment of these models.

While state participation is needed across the portfolio of federally-led APMs, we recognize and applaud the SIM program for providing critical support for the participating 34 states and the District of Columbia to drive statewide transformation. SIM has helped these states plan for or implement multi-payer delivery system and payment reforms, and it has been an important source of support for building the complex infrastructure needed for this work. A March 2015 NAMD & Bailit Health Purchasing study identified SIM funding as an important factor in advancing value-based purchasing in states.<sup>7</sup> It has been successful due to the level of

<sup>7</sup> "The Role of State Medicaid Programs in Improving the Value of the Health Care System." National Association of Medicaid Directors, Bailit Health Purchasing. March 22, 2016. [http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD\\_Bailit-Health\\_Value-Based-Purchasing-in-Medicaid.pdf](http://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf).

Financial investment, by empowering state leadership to drive transformation, and by recognizing the importance of state variation in delivery system and payment reform. Medicaid Directors believe a next generation of SIM could enhance and build upon this success.

States have engaged in other CMMI models as well, such as the Comprehensive Primary Care initiative and the forthcoming CPC+ Initiative. As with SIM, state participation in these efforts has been facilitated by flexibility for the state adaptation of the model to their unique landscape.

Finally, state participation in CMMI initiatives could also be facilitated by using administrative reporting structures that are streamlined and consistent. For example, reporting requirements related to content should be as consistent as possible over the lifespan of the initiative to minimize administrative burden. Similarly, states would benefit from a coordinated approach for providing updates on state participation in innovative models to CMS.

## **2. How can CMS/HHS better align in order to support state delivery system reform efforts?**

We believe there are a number of concrete opportunities for CMS/HHS to better align in support of delivery system reform efforts. In particular, CMS and HHS could:

- *Create a no wrong door approach for states to engage with CMS on health system Transformation, as well as a single point of contact for states to continue its work with CMS on these innovations.* Currently, it is unclear for states how they should approach CMS with a new concept, and what the process is for working with CMMI, CMCS and MMCO through the design and implementation of these initiatives.
- *Provide states with an expedited pathway for receiving approval of any necessary Medicaid authorities when implementing a CMMI-approved model.* States face significant delays after CMMI has approved a new state model because the Medicaid agency must still seek approval from CMCS for needed waivers, SPAs and managed care contract changes. This apparent lack of coordination between CMCS and CMMI delays states' ability to deploy a Medicaid and multi-payer model.
- *Ensure sufficient CMMI capacity to partner with states, including staff with state Medicaid experience.* As CMMI works with states to support state-led, multi-payer transformation through the next generation of SIM, it is important that CMMI have appropriate capacity to carry out this work. In particular, given the uniqueness of the Medicaid program, CMMI needs to ensure it has staff with robust state Medicaid experience.
- *The goals of health system transformation need to be inculcated throughout HHS, including in the day-to-day oversight of the Medicaid program.* State Medicaid Directors have expressed concern that some CMCS's policies and procedures may unintentionally discourage the



use of value-based purchasing and health system transformation. For example, when a state links a Medicaid reimbursement increase to value, the state faces a more significant administrative burden than when not linking it to value. Medicaid Directors encourage CMS and HHS to ensure there is broad alignment across all agency functions around value-based purchasing, including in the review of SPAs, waivers, and in the development of regulations and sub-regulatory guidance.

- *Articulate how new CMCS and CMMI initiatives fit together to support health system transformation.* CMS frequently launches new opportunities and initiatives to support health system reform, including a variety of new APMs, technical assistance through the Innovation Accelerator Program, and efforts under the HHS Health Care Payment Learning and Action Network. There is often a lack of clarity how these initiatives are connected and complement each other. States would benefit from a cohesive HHS strategy for how these initiatives fit together in support of value-based purchasing goals at the state and federal level.



*The National Academy for State Health Policy (NASHP) solicited feedback from state officials on the [U. S. Health and Human Services' Request for Information \(RFI\)](#) focused on state and federal payment and delivery system reform initiatives through conference calls and an in-person meeting at our Annual State Health Policy Conference held October 2016. This engagement included a cross-section of officials representing Governors' staff, insurance regulators, Medicaid, the children's health insurance program (CHIP), public health and state all-payer claims databases (APCDs). Recognizing that states will submit more detailed comments, we share here some general themes from those discussions.<sup>1</sup>*

### **Summary of State Feedback on the HHS RFI on Payment and Delivery System Reforms**

State officials expressed appreciation for CMMI's RFI and interest in opportunities to continue to reform delivery and payment systems. Officials noted their interest in: patient-centered medical homes for all populations, including children who have largely been left out of previous reform models; engaging all payers, including private, self-funded plans and Medicare in existing Medicaid payment reforms; and establishing global budgets for hospitals, particularly those in rural areas, as well as statewide all payer global budget approaches. However, excitement at the possibilities is balanced with the strain many state officials are feeling as a result of multiple, ongoing reform initiatives that are not always aligned. While state officials acknowledge responsibility for helping to achieve truly coordinated, aligned and sustained system reforms, they need assistance from their federal partners to do so. State feedback and comments generally fall into three overarching themes.

1. Support alignment at both state and federal levels
2. A focus on infrastructure and capacity
3. Broadening the focus to new partners

### **Support Alignment at both State and Federal Levels**

Whether they support state specific multi-payer approaches or efforts to align with existing Medicare models, states identified a need to be specific about how success will be measured. The state officials we engaged are eager to work on developing a broad goal that can be a guide for multiple federal and state agencies to work toward, and clearer measures to test how initiatives can be better aligned.

### **Simplify and build upon existing multiple delivery and payment reform initiatives.**

Many states are engaged in more than one delivery and/or payment reform initiative with CMS and different states are at various stages within these initiatives. Examples of the initiatives include: State Innovation Model (SIM); Delivery System Reform Incentive Payment (DSRIP);

<sup>1</sup> Disclosure: NASHP is a subcontractor participating in the evaluation of the State Innovation Model (SIM) grants awarded in rounds one and two. However, our facilitation of state officials to seek their input on the HHS RFI was separate and not part of, or informed by, our work on the SIM evaluation.

Comprehensive Primary Care Plus (CPC+); and the Transforming Clinical Practice Initiative (TCPI). States are also required to implement the final Medicaid Managed Care rule and the Medicare Access and CHIP Reauthorization Act (MACRA), which both call for reforms. Although officials are committed to testing and then supporting lasting health reform changes in partnership with the federal government, they request opportunities to align their current efforts with future engagements. A recent [NASHP brief](#) highlights the complexities states are facing in the planning for and implementing changing demonstrations and reforms.<sup>2</sup>

Those state officials actively engaged in multiple initiatives and reforms cite difficulties navigating silos within CMS and across various HHS agencies. Different arms of CMS have different requirements that can be time-consuming and frustrating for states to navigate. Enthusiasm for the opportunities presented by the RFI is tempered by concerns about implementation challenges.

### **Suggestions:**

- **Reconsider outcome measures and identify shared goals.** In considering measures, states and the federal government must first identify their shared ultimate goal(s) for these reforms. A goal to increase quality and reduce costs for high-need, high-cost medical interventions requires different measures than the goal to improve the overall population's health and may require different time periods to reflect measurable results. For example, outcome measures should be changed from disease-based to systems measures that span sub-population groups. Measures should be developed in collaboration with state input. Greater regulatory coordination within CMS and across HHS agencies would improve states' capacities to implement reforms. Approaches to payment and delivery reforms across federal payers (Medicaid and Medicare) are different and need to be aligned at the federal level. States and the federal government also share regulatory oversight for private insurance that could be better aligned.
- **Balance state flexibility with adaptability to advance design and evaluation efforts.** Though the "thousand-flowers-bloom" approach of past SIM initiatives has allowed great innovation and experimentation in health care delivery and payment reform, it has also resulted in the current calls for greater alignment. One potential strategy to create better alignment across initiatives and across states is for CMS to consider developing a set of flexible, adaptable templates for states to work from on further delivery and payment reforms. While states have mixed opinions about the demonstration itself, the three tracks outlined as part of the Accountable Communities for Health Model were cited as an example of a CMS initiative striking a good balance between the need for direction and flexibility.

### **Focus on Infrastructure and Capacity**

State officials identified a number of capacity and infrastructure issues both internal and external to the state that need attention to achieve and sustain meaningful delivery and payment reforms.

### **Data collection, analysis, and dissemination necessary for multi-payer payment reform.**

Some state officials have concerns about their data systems infrastructure to successfully collect, analyze and share the information necessary to implement and monitor multi-payer payment

<sup>2</sup> *Federal-State Discourse on Maintaining Momentum for Payment and Delivery System Reform* - <http://www.nashp.org/wp-content/uploads/2016/09/Discourse-Brief.pdf>

reforms. Although there have been significant federal and state investments in data infrastructure to allow for comprehensive collection and analysis, there is still work to be done at the systems level. There are a growing number of states that have either built or are interested in creating an all-payer claims database (APCD) to collect foundational information for reform efforts.

In addition to systems issues, states also need to ensure agency staff capacity to adequately understand, validate, and disseminate the type of data necessary for multi-payer payment reform. Such capacity is essential to effectively using data, but is challenging to gain.

### **Suggestions:**

- **Provide specific technical assistance** to offer trainings that states can adapt to educate their existing staff on the emerging data analysis criteria needed to appropriately utilize changing data systems.
- **Enable more vigorous data collection and analysis capacity.** CMS could facilitate a more robust data collection and analysis capacity in the states by investing in state APCD systems. These systems can be invaluable tools to advance multi-payer reforms by collecting and reporting data across payers at a state level. Today, APCDs are the basis for work to promote cost and quality transparency, track health care drivers and trends, and promote public health. As reported earlier by NASHP<sup>3</sup>, examples include:
  - Assessing geographic variation in price and utilization. The Oregon Health Authority publishes quarterly reports that compare per-member per-month costs and utilization by service category for the commercially insured, public employees, and public payers. Maryland uses APCD data to compare the unit costs, utilization, per-member per-month costs, out-of-pocket and insurance payments, geographic variations, and physician access data across geographic regions.
  - Promoting cost and quality transparency while protecting consumers. Both New Hampshire's Health Cost and Maine's Compare Maine websites offer provider-specific price and quality information to consumers, health plan enrollees, and employers to promote health care comparison shopping through cost- and quality-transparency tools. Both systems have historically included multi-payer data.
  - Tracking health care spending drivers and trends. Massachusetts used its APCD data to produce an annual report analyzing trends in health care spending for commercial payers by category of service, type of episode, and geographic area. Minnesota used its APCD data to analyze prescription drug spending by therapeutic category and setting (office-administered vs. pharmacy benefit). Rhode Island released a report analyzing the top 15 clinical complaints and associated costs of potentially avoidable emergency room visits broken down by payer type.
  - Promoting public health. Organizations in Virginia and Utah have used APCD data to track opioid prescription claims across geographic areas and patient

<sup>3</sup> Comments on Department of Labor Notice of Proposed Rulemaking Docket # ERISA – 2016-0010; RIN 1210-AB63, Submitted by NASHP in collaboration with NAHDO and APCD Council, September 20, 2016

characteristics to understand and address trends in opioid use. New Hampshire used APCD data to measure access to and utilization of preventive services, such as cancer screening or diabetic testing and treatment, among its adult Medicaid population.

The potential of APCDs is significant, and could be coupled with available state level clinical data, to be an even more important data sources for multi-payer payment reform. NASHP supports the comments submitted by the APCD Council and NAHDO in response to this RFI, which provide more detailed response to CMS questions. We believe that the foundation exists upon which to build APCDs in each state and strengthen the data collection in all of them. However only 19 states have enacted legislation to administer APCDs and the recent Supreme Court decision, *Gobeille v. Liberty Mutual*, which limits the ability of APCDs to collect data from self-funded plans, stymies the growth of APCDs. Importantly, APCDs have developed and agreed to a Common Data Layout that would provide consistent data across all APCDs and lessen the burden for self-funded plans to report to each APCD. CMS, in collaboration with the US Department of Labor, which oversees ERISA plans, could together strengthen and make nationwide APCD data reporting. CMS could invest in APCD development in states without such programs, strengthen that reporting in states with active APCDs, embrace the Common Data Layout, and working with the Department of Labor, enable states to continue to collect data from self-funded plans in order for all states to generate data they need to effectively implement multi-payer delivery and payment reforms.

### **Broaden Focus to New Partners**

While challenging, state officials also expressed the need to engage new partners in continued reform efforts. Truly *all* payers, medical and non-medical providers, and even other states were identified as important partners in future efforts.

### **Partnerships among varied and multiple stake holders including Medicare , commercial payers and self-funded plans, are essential to achieving reform.**

Reform initiatives that engage and achieve buy-in from health care providers and different payers (including commercial and self-funded employer plans) are necessary for successful reform. States can leverage their own purchasing power through Medicaid, CHIP, state employee and retirement health plans, but need to do more. Incentives that support this collaboration in federal demonstrations can prove helpful. States want to better engage other payers, including Medicare in reform initiatives. One state official identified “the power to transform as residing in all the entities acting together” and was pleased that the RFI suggested a path forward where Medicare would be more engaged in the mix of payers in state based efforts

Effective multi-payer payment reform must reach beyond Medicaid and Medicare to engage commercial and self-funded plans as well, though states influence is limited in this sphere due to ERISA. As previously noted, sharing all payers’ claims data is a major barrier. However there are other inconsistencies across payers, even between Medicaid and Medicare, that if addressed could help further build partnerships for reforms.

### **Suggestions:**

- **Engage the Department of Labor.** Given their oversight responsibilities of ERISA health plans, the Department of Labor should be more actively engaged in these reform efforts.

- **Identify barriers to alignment.** A workgroup of federal and state officials should identify the areas within Medicare and Medicaid that are barriers to alignment and work together to address them in order to support sustainable delivery and payment reform efforts.

**Public health and social determinants of health must play a more prominent role in delivery and payment reforms.**

Existing public health efforts should be incorporated to address population health within delivery system and payment reform efforts to avoid addressing health solely through clinical care. States and the federal government still have work to do to create a functioning “ecosystem” with links between medical and non-medical providers, including linking data.

**Suggestion:**

- **Address social determinants of health.** The goals of [Public Health 3.0](#) could be adopted to address social determinants of health, such as transportation, which is vital to achieving improved health outcomes.
- **Engage non-medical providers.** Future reform efforts must include a mechanism for explicitly engaging non-medical providers, such as social workers or schools for youth, perhaps through incentive payments, to help ensure connections with social determinants of health.

**Opportunities for cross-state care interventions could be appealing, but need consideration.**

Several states indicated interest in the RFI’s proposal of specific care interventions that could be implemented across multiple states. Behavioral health integration was cited as a potential focus for such work. Cross-state care interventions could be a potential means to ensure access in underserved areas. There were however, concerns about potentially forfeiting autonomy on the state side and issues with accountability and coordinating different regulations and standards across state lines

**Suggestion:**

- **Tele health.** Expand and evaluate current efforts in telehealth that allow access to care across state lines, addresses particular scope of practice liability issues, and state licensing and oversight requirements

**NASHP applauds CMMI’s RFI soliciting comments to inform future work. We offer these general comments to reflect some of the key themes we have heard from states in response to it.**

**Aetna Response**  
**Request for Information on State Innovation Model Concepts**  
**Submitted to: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov), October 28, 2016**

As the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (the Innovation Center) seeks input from stakeholders on how to shape and improve the next round of State Innovation Model (SIM) Grants, Aetna offers the following recommendations for consideration.

**Section I – Part 1**

- 1. Integrate multi-payer members into SIM models.** Where possible, the Innovation Center should encourage integrating Medicaid, CHIP and private insurance members into demonstration projects. This would help accelerate the shift to value base payment and align with two important aspects of MACRA:
  - a. the qualifying thresholds that require health care professionals to receive a percentage of their services through qualified alternative payment model (APM) entities in order to qualify for bonus payments and higher fee schedule updates; and
  - b. The All-Payer Model that would pay health professionals APM bonus payments and higher fee schedule updates if they receive at least 50 percent (75 percent in later years) of the sum of their payments through Medicare and other payers that are risk bearing coordinated care models.

**Section I – Part 2**

- 1. Allow SIM models to integrate social supports and other services.** As part of the SIM grant process, the Innovation Center should allow reimbursement for services that are not considered part of traditional medical treatment, but have a significant impact on improved outcomes. These types of services include community based mental health treatment, housing support, employment assistance and training, and other programs that have been proven to accelerate and improve the social determinants of health.
- 2. Support telemedicine efforts, especially in rural areas.** The use of technology has the potential to improve the delivery system and increase access to care, especially in remote and rural areas. Where possible, the Innovation Center should support initiatives to pilot and expand telemedicine initiatives.

**Section I – Part 3**

- 1. Promote data sharing and effective communication.** The Innovation Center and States should require SIM grant participants (including the State itself) to share historical data and outcomes based results from the SIM projects. This will help focus stakeholders on how to accelerate the shift to value based payment. An optimal starting point is development of an all payer claims database

which initially houses Admission, Discharge, and Transfer (ADT) data. This would allow facilities and providers the opportunity to understand patient access in the system, identify those patients who need intervention for disease exacerbation, and help recognize patients who may be doctor or pill shopping (opioid and substance abusers). The Innovation Center also could use the initial round of SIM projects to establish a set of key metrics that were collected to establish benchmarks and focus data collection and reporting for future SIM projects.

## **Section II**

### **1. All flexible service areas for SIM models.**

- a. To align and take advantage of existing value based provider contracting arrangements (between insurers and providers) and innovation investments as well as other demonstration initiatives, the Innovation Center and States should allow SIM grant service areas that may or may not cover an entire state. For example, some projects could include only specific cities, counties, or regions.
- b. We also recommend that the Innovation Center and States consider allowing multiple states to submit joint proposals that cross state lines. Although Medicaid is a State program with rules and regulations set by each State, Medicaid enrollees (especially those who live near a State border) do not exclusively utilize providers in their State of residence. They often follow natural boundaries and travel patterns that are not limited by a State border. We recommend States and the Innovation Center evaluate the local area dynamics (for example, sections of NJ and PA, where crossing borders to access health care is common) and, in those instances, allow multiple states to submit a SIM grant proposal. This approach would help drive innovation of the health care delivery system at the local level, regardless of a State's border.

## **Section III**

1. Recommend improved alignment between Federal and State requirements for SIM participants. While a lot of work has been done in this area with the Medicare-Medicaid Plan Financial Alignment Demonstrations (MMP), more can be done. For example, with the existing MMP Demonstrations, CMS has a requirement that care assessments be complete within 90 days, however, some States have a shorter timeframe requirement for the same service. We recommend the Federal Government take steps to align with States' efforts. We recommend focusing alignment efforts around:

- i. IT requirements/investment
- ii. Data sharing
- iii. Thought process commonalities
- iv. Quality Metric Alignment
- v. Member enrollment and beneficiary protections
- vi. Value based contracting requirements



## Next Steps for the State Innovation Models Initiative Request for Information

The State Innovation Group released Request for Information to help CMS prepare for the future of state-based delivery system and payment reform. The State Innovation Models (SIM) Initiative has supported over 38 states, territories, and the District of Columbia in two rounds of awards. The Centers for Medicare & Medicaid Services (CMS) has set ambitious goals for health system transformation, and they recognize that much of this transformation will ultimately occur at the state and community level. Our investment in SIM is a recognition of the important role states play as a locus for change to accelerate transformation, and their unique leverage point to implement models consistent with the proposed Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

### SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is seeking input on the following concepts related to state-based payment and delivery system reform initiatives:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive;
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

**Response from Rhode Island:** Several groups of Rhode Island SIM stakeholders participated in crafting responses to this CMS Request for Information, including community members of our Steering Committee, state SIM staff members, and members of our Interagency Team.

We are sharing our overall responses here, and then have answered a number of the specific questions below.

In general, Rhode Island is tremendously grateful for the opportunities that our SIM grant has given us, and we encourage CMS to continue to support payment and delivery system reform initiatives in the future. We suggest:

- a. Increased back and forth communication between CMS and State Governments on innovation opportunities. We think that in general, more regular communication will lead to better working relationships, understanding and successes.
- b. Increased funding and funding opportunities, with Medicaid participating in innovation projects, to make them fully multi-payer. Examples include:
  - Medicare investing in support for PCMHs, along with other carriers at the state level
  - More opportunities for states to receive funding from CMS for innovation, because it's difficult to raise money for innovation testing at the state level

- Allowing state recognized PMCHs reciprocal participation in CPC+
- c. Expanding the focus on social and environmental determinants of health.
- d. Having CMS reduce some of the restrictive criteria within incentive programs, which would enable more providers to participate. (e.g. Reciprocity for State Recognized PCMHs)
- e. Having CMS allow states more flexibility in adapting models within each state to facilitate reaching the same specific and desired outcomes.
- f. Multi-state initiatives where they make sense – i.e. changes that would control prescription drug costs that can only work nationally

## Section I Multi-Payer State-Based Strategies to Transition Providers to Advanced Alternative Payment Models

### QUESTIONS:

1. What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?
  - a. What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?

Rhode Island has been quite successful in achieving all payer alignment through our multi-payer organization, the Care Transformation Collaborative Rhode Island, and its participation in the MAPCP project. Many care transformation leaders in Rhode Island are concerned about CMS rules that will restrict next generation ACOs from participating in CPC+, noting that such restrictions slow all payer alignment. For example, two very large ACOs in Rhode Island are scheduled to begin MAPCP in January 2017 and were therefore unable to apply and continue all-payer programs.

Additionally, CMS' standard template contracts and somewhat prescriptive, uniform transformational roadmap limit ACOs from having individual contracts with a variety of payers. If ACOs had flexibility to tailor the contracts and include pilot programs to fit sub-populations within the state, they would be more successful. Moreover, ACOs need the leeway to adjust contracts to be PCP only or include specialist providers (i.e. maternity bundle) and/or hospitals.

In addition, behavioral health providers continue to struggle with lack of funding for necessary IT enhancements. Medicaid, Medicare, and private insurance cover include vast differences in coverage options and provider qualifications, which demands a sophisticated IT system in order to adjudicate payments appropriately.

However, especially from a data perspective, the biggest challenges in achieving all payer alignment lie in protection of trade secrets, and as we note throughout, our desire to have Medicare participate in alignment.

We have had some issues where payers have been cautious about sharing certain types of data to aid our transparency efforts, such as provider network data for the SIM funded Statewide Common Provider Directory, and claims data from self-funded insurers for which they act as Third Party Administrators. The effort to achieve transparency is likely a cultural change that will occur over time as trust is built and consumer expectations transform. While we could push to use state powers to mandate participation, we prefer to achieve alignment where all parties participate voluntarily.

CMS encourages multi-payer models for activities funded by Medicaid, so it is understandable that the commercial payers and MCOs would like to see the Medicaid FFS also participate. It would further solidify the value of commercial payer alignment, if there was a mechanism in place that would ensure Medicare participation in activities where all of the payers in our state have come together and agreed upon an alignment model. This could range from just accepting the measures we have aligned at the Medicare level, to supporting some multi-payer funding models. For example, the payers in Rhode Island have agreed to pay a PMPM fee to support and sustain our Health Information Exchange. Medicare patients definitely benefit, even disproportionately, from our HIE, but Medicare does not contribute to this funding model and there is no mechanism we are aware of to request that participation.

- b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?

These initiatives should help to decrease rather than increase administrative burdens on practices. Layering additional reporting requirements and/or transformational expectations that are not in line with existing programs can create resistance from potential candidates. We could achieve these goals by placing expectations on commercial payers to conform to an agreed upon set of expectations so that everyone is operating under the same expectations.

To attract new practices, some of our leaders have suggested that there be more nascent options. Most of the practices willing to join progressive programs have already done so. The remaining practices have resisted this long, and apart from significant disincentives will continue to remain on the sidelines. We were hoping that the dramatic incentives of CPC+ would attract these remaining practices, but it did not. If they will not go into a program like CPC+ with all of its expectations, then perhaps we need to consider less advanced options that would still put them on the right path.

- c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?
- d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth

In spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?

Several Rhode Island leaders noted that CMS should find a balance of flexibility in programs and prescriptive guidance. States need the flexibility to adapt a program to fit their populations. Too much flexibility, too many options, or multiple variations of a theme can lead to confusion. More SIM funding opportunities that would allow states to bring the transformation down to the ground level to work with practices would be welcome.

In addition, as mentioned earlier, support from Medicare to participate in our multi-payer funding models for our initiatives, such as HIT infrastructure, would greatly solidify the value of multi-payer alignment initiatives.

- e. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?

In Rhode Island we see stakeholder involvement in our planning efforts as a major benefit to the planning process. Therefore, we suggest that at least a year for planning and 3-4 years for implementation would be required. Some more programmatic projects can be implemented on shorter timelines, but in our experience, HIT infrastructure that reaches critical mass requires several years of development. Some of the larger issues we face in implementing projects on shorter timelines involve the hiring and procurement process. If funding could line up with the end of SIM Test Grant funding, we could retain staff and institutional knowledge that would accelerate the timeline considerably.

- f. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?

It is important to have a common set of outcome metrics on quality and cost. The models can differ, but if states have similar outcomes, they can be effectively evaluated across state lines.

- g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?

To achieve multi-payer models, we think that CMS should allow all providers – including those in existing CMS initiatives – to also participate in multi-payer state initiatives.

- 2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate Population health improvement into core care delivery and payment incentives structure that

includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.

- a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do currently use (or are exploring) that could be linked to payment.

Several Rhode Island practice transformation leaders had these comments for this question:

- Continued use of pay for performance programs for quality measurement and performance
- Stronger disincentives for failure of practices to align with ACOs or multi-payer programs (like CTC Rhode Island in our case)
- Now that we have created the SIM Aligned Measure Set, we need to use it, along with MSSP quality and cost based measures, and quality programs from our specific carriers (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and UnitedHealthcare (HEDIS and CMS Stars driven)
- There is growing research that employment or other meaningful activity and stable housing contribute to more positive health outcomes. Both should be linked to care delivery and financial incentives
- If a provider is recognized as PCMH by a formal state process (such as Rhode Island's Office of the Health Insurance Commissioner's process), CMS could offer reciprocity based on that official determination.
- Finally, In order to link financial incentives to health outcomes of a population, we need powerful and accurate statewide analytics systems, such as our All Payer Claims Database. These systems are expensive to maintain and while they can achieve partial sustainability through data release, they require ongoing support. Our APCD was funded by Rate Review grants and now through SIM. Beyond SIM, we believe our APCD is key to Medicaid operations in a transformed healthcare system, and will be moving the database to become a module of our Medicaid Enterprise. We are seeking enhanced match to support the further development and maintenance and operations of the APCD going forward.

- b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?

The perspective of some of SIM's leadership is that the measures of success are not different in rural communities, however, there are different strategies required to obtain successful outcomes and we should pursue those.

c. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?

3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.

a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?

b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and healthcare data; appropriate measures)?

Rhode Island leaders noted that for quality reporting purposes, claims based measures only go so far, so an APCD alone does not suffice. Provider reporting measures complement this information. However, information on social determinants of health are not consistently captured and are therefore difficult to consistently track.

c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?

d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?

Capacity to use our data for meaningful analysis can often be limited by state and federal privacy laws. We have learned to work within the privacy framework requested by our community, but we are still greatly limited in data use for 42 CFR Part 2 facilities and there is a general lack of knowledge of what is allowed or is not allowed around their data.

e. What support can CMS provide to improve states' access to reliable and timely data?

Federal requirements for insurers and providers to participate in state models, such as submitting data to APCDs or Provider Directories, and community health teams may be helpful. There are mechanisms within CMS to reach most of the payers in the country and give them requirements to participate in state initiatives. One provider representative in an MSSP program noted that they get exception data from CMS, but she did not think that that happens across the board in smaller practices.

f. How can CMS support improve access to and linkage with health outcomes measures data?

Our provider representative noted: even for an MSSP group, quality data is determined by a random sampling and attestation process. CMS can assist in claims based measures.

g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?

h. What IT infrastructure is available to states to use data to support transformation efforts? (E.g. Infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?

We are still working on establishing this infrastructure in Rhode Island, and SIM funding has been a major aid in getting it established. We really appreciate the ability to use SIM to receive Medicare claims files at no cost, and this has been very helpful in increasing the value of our APCD.

We also know that the information practices receive varies greatly by the value based contracts in which they participate. Practices also vary in their ability to digest the data in a meaningful way from payers or through analysis conducted using EHR data, claims-based information or a combination of the two. There must be a collaborative approach between IT and clinical staff to ensure reports are written correctly. An iterative validation process is also necessary to ensure correct processes.

## SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

CMS is interested in assessing the impact of specific care interventions across states. States would have the option of seeking supplemental awards, and in return would agree to implement a standardized care intervention in areas CMS and states agree are high priority for rigorous assessment (e.g., care interventions for pediatric populations, physical and behavioral health integration, substance abuse/opioid use treatment, coordinating care for high-risk, high-need beneficiaries) and participate in a robust evaluation design led by CMS. Unlike SIM Round 1 and 2, states would forego the flexibility of varying the intervention, so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.

### QUESTIONS

1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).

One of our behavioral health experts was concerned that states would need to offer a choice of the standardized approach being tested or the traditional provider prescribed approach in order to avoid legal or other formal challenges by advocates, provider associations, or families.

2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need



to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?

Our leaders had questions about the expectations CMS would have about participating across state lines. As noted above, there is interest in participating in efforts that cannot be addressed at the state level (such as prescription drug pricing reforms), but not necessarily where Rhode Island would be farther along in our development on a reform issue and where the test would be on a potentially less developed intervention.

3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.

There may be opportunities to streamline Nurse Care Manager Interventions and high risk patient engagement. In addition, we would suggest looking at supported housing and employment/meaningful activities as health care interventions, as well as some focus on transition-age youth.

4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.

Some of the disparities exist and are reporting in areas outside the clinical setting, or at a minimum present themselves more in a BH/MH setting rather than medical. For non-clinical interventions, better coordination must exist so that the PCP and care team fully understand the spectrum of concerns the patient is facing in all aspects of his/her life. Somehow we need to better coordinate the exchange of information across medical and social agencies.

One behavioral health expert noted that providers that deliver holistic health care, behavioral health care and social services are experiencing success with vulnerable populations. A comprehensive provider system affords the opportunity for people to have a comprehensive care plan, receive readily accessible services in a coordinated and timely manner, promotes culturally competent services and reduces barriers to sharing information. But disparate regulations and payment issues at both the state and federal levels can create hardships for these approaches. Billing and payment for services can be so complex that agencies that do deliver comprehensive approaches have to either invest large amounts of funding (often through loans) in order to have the necessary IT and billing systems to bill across multiple funding sources or they rely on foundations and charitable contributions, which are increasingly difficult to obtain, to help pay for the services. Federal Health Centers are a step in the right direction but cannot always include the social service interventions often necessary for these vulnerable populations. "Culturally competent" services are essential for gaining trust of vulnerable populations including linguistic competence, gender-identity, and military culture...things we know yet continue to fall short on.

From the data perspective, we know that some of the data that we would need on our populations to truly understand the disparities in enough detail to target successful interventions are not traditionally gathered in health records. Incentivizing Medicare providers to collect socioeconomic status indicators as part of QPP, and incorporating those elements as structured data feeds in CEHRT, might be a necessary first step to changing the culture of what data is helpful in determining the correct care plan for their patients. For example, income, household size, homelessness status, race, ethnicity, gender identity, education, health literacy, and means of transportation would all be helpful fields to have in our state level analyses to make our planning more successful, but are rarely collected by most providers. Furthermore, those data elements could have a lot of value for the providers in determining the best care plan for their patients.



Here are some other suggestions about how to address disparities:

- Educate providers to adopt a bio-psycho-social model of medicine and identify local barriers to healthcare that are affecting a provider's patient population.
- Increase patient education within PCP offices, PCP/Hospital discharge summaries and interventions that are culturally and linguistically appropriate, as well as delivered at the patient's literacy level.
- Embed social services personnel in healthcare settings serving populations with health disparities, both urban and rural, and especially in the FQHCs.
- Provide counseling services in medical office on medical costs, insurance coverage, and preventative medicine/behavioral services offered by CMS and/or private plans.
- CMS reimbursement for transportation services for healthcare.
- Develop community based education on managing/understanding one's own health (including topics such as health insurance, nutrition & fitness, basic care at home) and offer incentives for those who attend.

### SECTION III: STREAMLINED FEDERAL/STATE INTERACTION

CMS seeks input on how to improve both coordination among related federal efforts in support of state based delivery and payment reform efforts (e.g., workgroups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

#### QUESTIONS

1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?

We appreciate the opportunity to provide this information to CMS, as well as the assistance that our SIM Program Officer and other program staff provide us. In general, as noted above, we think that open lines of communication between CMS and the states on these innovation possibilities is very important.

2. How can CMS/HHS better align in order to support state delivery system reform efforts?

**SPECIAL NOTE TO RESPONDENTS:** Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

October 28, 2016

The Honorable Andy Slavitt  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-3323-NC  
Submitted electronically

Re: Request for Information on State Innovation Model Concepts Dear

Acting Administrator Slavitt:

The National Governors Association Center for Best Practices Health Division (Health Division) appreciates the opportunity to submit comments in response to the Request for Information (RFI) on State Innovation Model (SIM) concepts. Within the Health Division, we work with Governors and state leaders from across the nation on their most pressing issues, including aligning economic incentives to improve care and health outcomes for state populations while lowering the growth of health care costs for states, patients and taxpayers. This response is informed by our work across the country.

Faced with budgetary challenges coupled with a commitment to improving the lives of their residents, governors have led efforts to organize and launch transformation of the health care systems in their states. Such reform efforts often start with the Medicaid population and recognize that meaningful and sustainable change depends on reaching broader populations such as state employees and retirees, Medicare beneficiaries, exchange populations and individuals with employer sponsored insurance. The SIM program has provided critical support to states by providing resources focused on building the capacity and infrastructure needed to create and launch statewide plans to transform health care systems. **We strongly urge CMS to continue and expand SIM opportunities in the states; and in particular, to fund additional rounds of SIM testing grants.** Continued funding would allow states to effectively move forward in implementing plans they have invested significant time in developing and leverage the stakeholder commitments secured toward collaboratively achieving healthier populations through payment and delivery system reform.

Governors and their staff are faced with a complex pathway to achieving payment and delivery system reform. We fully support CMS's efforts to improve alignment of health system transformation at the federal and state level. We also urge CMS to consider specific strategies that will provide states with direct step-by-step guidance on how to achieve multi-payer alignment and implement successful provider transition strategies, as addressed in more detail below.

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- **Identification of Specific Models of Successful Transformation Efforts:** Governors and their staff would benefit from the identification of specific advanced alternative payment models (APMs) and other transformational reforms from public or private payers that are resulting in a return on investment through increases in quality and outcomes as well a reduction in growth in health care costs. Models to highlight may include efforts that are successfully migrating providers to risk and those that result in improved behavioral health outcomes. States also would benefit from direct technical assistance (TA) from a non-governmental entity on how to use these metrics to develop state level and national level reports with benchmarks.
- **Development of a National Core Set of Metrics to Evaluate Overall Population Health:** One of the key challenges for states in transitioning providers to APMs is the myriad of metrics that providers must adopt from different payers and concerns around their ability to track and apply so many different metrics. States would benefit from the development of a voluntary, national core set of metrics (no more than 15-20) that relate to unified domains within population health and could apply across all public programs and the exchanges. Such unification would ensure more consistent "directional" change in the U.S. health care system. In developing these metrics, it is critical to work with governors, providers, payers, consumers and other national experts, to ensure that different perspectives have been considered and that there is sufficient buy-in for the metrics themselves. In developing the metrics, considering leveraging the outstanding *Vital Signs* work at the National Academy of Medicine, which provides a framework for national metrics.<sup>1</sup> These metrics also should incentivize evidence-based and emerging best practice and disincentivize practices that have not been shown to be effective. States will require the flexibility to determine which of these metrics should apply to their unique populations, such as certain Medicaid recipients.
- **Providing Technical Assistance to States in Migrating Providers to Risk:** States would benefit from direct TA that identifies specific strategies of how to partner with providers to migrate them toward taking on risk, including how to involve and get buy-in from stakeholders, how to build the platform to make this shift, and how to develop a set of metrics to evaluate the migration by providers.
- **Increased Use of Data for Transformation Efforts:** Data exchange and analysis are critical elements for designing and implementing payment and delivery system reform. Specifically, there needs to be meaningful and robust data exchange to ensure that provider payments can be tied to not just capability but the actual exchange of data. State Medicaid programs also have specific challenges around accessing complete and reliable Medicaid data in a timely manner - which is a substantial roadblock to implementing delivery and payment system reform. Governors and their staff are seeking ways to improve their Medicaid data systems and they would greatly benefit from direct TA on options for (i) how to effectively purchase and manage data systems (including new modular systems), (ii) how to effectively build state capacity managing and maintaining data systems; and (iii) improvements in how states procure their data.
- **Increased Alignment Between Medicare and Medicaid at the Federal Level:** CMS has been engaging in significant transformation of the Medicare program through building a path to APMs with providers. This has created a clear signal in the market of where providers will need to move to within the next few years. In parallel with these efforts, many states have identified pathways towards APMs in the Medicaid program and have often tried to create some level of uniformity between the programs. However, given the differences between the Medicare and Medicaid populations, achieving some level of uniformity has been challenging. We would suggest that CMS create an ongoing and more transparent dialogue on how to improve the alignment of VBP efforts for the Medicare and Medicaid programs and to engage governors and others in this process to identify where challenges have remained insurmountable and where opportunity may arise for comparable changes in both programs.

<sup>11</sup> J. Blumenthal, E. Malphus, J.M. McGinnis, *Vital Signs: Core Metrics for Health and Health Care Progress*, National Academy of Medicine, Institute of Medicine (2015).

- ***Direct and Intensive TA on Alignment Across States.*** Successful transformational efforts at the state level require collaboration and alignment across many different parts of state government - such as collaboration among Departments of Health and Human Service (including Medicaid), Education, Insurance, Labor, Corrections, state Housing Authorities and others. Often, however, state leaders work in silos. In order to increase the likelihood of sustainable and effective change, states would benefit from direct and intensive technical assistance on how to align transformational efforts across state government. Such TA would include clarifying how federal programs, funding, requirements and evaluation strategies can be aligned to improve cross-agency collaboration at the state level.
- ***Medicaid Leadership Training*** States often begin their journey to APMs with their Medicaid programs. Consequently, Medicaid directors are at the helm of so many of these discussions. To facilitate the acceleration along a path to APMs, we believe that intensive training on APMs and leadership should be provided to Medicaid directors around APM and other transformational efforts.

Thank you for your attention to these recommendations and your continued support of the SIM program. The SIM program is a critical element in governors' work as leaders in transforming health care payment and delivery systems in their states. We look forward to working with you in partnership to achieve the goals of better alignment of transformation efforts and identifying concrete steps of how to transition providers to advanced alternative payment models, with the ultimate goal of delivering higher-value care and better outcomes for residents.

If you have any questions or require additional information, please feel free to contact me at 202-624-7872 or [fisasi@nga.org](mailto:fisasi@nga.org).

Sincerely,

Frederick Isasi  
Division Director  
NGA Center for Best Practices Health Division

cc: Stephen Cha, MD  
Director, State Innovations Group  
Centers for Medicare and Medicaid Services



**Response to the Center for Medicare and Medicaid Innovation's  
Request for Information on State Innovation Model Concepts**

Submitted by email: [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

October 28, 2016

**Contact:**

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## **Introduction**

Freedman HealthCare is pleased to respond to this Request for Information on State Innovation Model Concepts. We commend CMS for looking to existing state data collection models as resources for analysis and evaluation of the effects of CMS investments in payment and delivery system reform.

## **About Freedman HealthCare**

Established in 2005, Freedman HealthCare (FHC) is a national consulting firm that works with a range of clients to put health data to work to solve complex problems. As strategists, FHC consultants help clients identify and understand the best sources of data to inform the development of effective strategies and operations models. Armed with this critical information, FHC clients are better prepared for policy and programmatic changes that will result in operational growth, quality improvement, and results-based accountability.

FHC's experience in 25 states across the country – each with different political climates, legislative requirements, and approaches to healthcare reform – have demonstrated the firm's skills in developing flexible, client- and state-specific processes. This commitment to customized healthcare improvement strategies echoes through FHC's concentration on mobilizing data to leverage change. The firm's depth and breadth of expertise is matched by the teams' skills in effective planning, project management, and stakeholder engagement.

FHC helps state health organizations and regional collaboratives utilize cost and quality data to inform policy initiatives. FHC has experience with 14 states that are either considering or implementing All Payer Claims Databases (APCD). FHC's seasoned consultants leverage their professional roots in government, clinical settings, and public health organizations as they work with clients to engage and inform diverse stakeholder groups in transformative projects. Services include stakeholder engagement, statutory and regulatory support (including data specifications), data management vendor contracting support and project management, data quality strategies, and data release policy and program development. FHC is unaffiliated with all of the data management vendors in the APCD space and offers clients impartial, informed assistance to states during contracting processes and during subsequent operational phases.

## **Benefits of APCDs**

APCDs are valuable public assets that can serve a range of current and future needs. Sixteen states currently operate APCDs, which are large-scale, multi-payer databases that systematically collect detailed health plan data, including: member eligibility information; medical, behavioral health, pharmacy and dental claims (including the actual payment amounts for all services); and provider information. APCDs contain cross-payer and cross-setting information that is critical for work in pursuit of the Triple Aim of better care, healthy

people/healthy communities, and affordable care,<sup>1</sup> and that is unavailable from other data sources. For example, hospital-discharge datasets contain inpatient hospital information but include limited or no information on outpatient care or the amount paid for services. Similarly, Medicare data provides insight for Medicare beneficiaries only, and since Medicare uses administered pricing, the Medicare data sets alone shed little light on market-wide health pricing and other economic questions. By virtue of their rich and broad data, APCDs support many public health, policy, performance improvement, and consumer empowerment goals. The table below highlights several relevant examples of ways in which APCD data can be used.

Role	Examples
Public health	<input type="checkbox"/> Incidence and prevalence of illness and injury <input type="checkbox"/> Disparities in health and treatment, by age, gender, socioeconomic status, geography, and payer or coverage type <input type="checkbox"/> Monitoring topics of interest, such as opioid prescribing, treatment of overdoses, and utilization of inpatient and outpatient substance abuse services
Market reform and consumer empowerment	<input type="checkbox"/> Price transparency tools <input type="checkbox"/> Comparative quality of providers <input type="checkbox"/> Modeling alternative payment models <input type="checkbox"/> Examining consumer out-of-pocket expenditures
Market function and health economics	<input type="checkbox"/> Market share of insurers and providers <input type="checkbox"/> Provider price variation <input type="checkbox"/> Analysis of effects of proposed mergers or expansions <input type="checkbox"/> Quantifying cross-subsidization by socioeconomic status <input type="checkbox"/> Evidence-based health care policy development
Performance measurement and improvement	<input type="checkbox"/> Quality measurement and reporting <input type="checkbox"/> Tracking patient outcomes of drugs, devices, and procedures <input type="checkbox"/> Population health management <input type="checkbox"/> Predictive modeling over time and across payers <input type="checkbox"/> Practice pattern variation <input type="checkbox"/> Risk-adjusted total medical expense <input type="checkbox"/> Accountable Care Organization performance and benchmarking <input type="checkbox"/> Hot-spotting extreme patterns to identify needs and develop interventions <input type="checkbox"/> Utilization rates <input type="checkbox"/> Actual vs. expected access to care as affected by consumer out-of-pocket expenditures
Research	<input type="checkbox"/> Rare diseases <input type="checkbox"/> Health services research <input type="checkbox"/> Evaluation of aspects of health care reform <input type="checkbox"/> Clinical effectiveness research <input type="checkbox"/> Cost effectiveness analysis <input type="checkbox"/> Impact of electronic health records (EHRs)

<sup>1</sup>Department of Health and Human Services (HHS). Report to Congress: National Strategy for Quality Improvement in Health Care. March 2011. Available at: <http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2011annlrpt.pdf>.

Across all of these priority areas, APCDs complement and augment existing data sources by leveraging the power of large numbers to increase the understanding of health, health insurance, and health care delivery in the United States. APCDs offer a comprehensive source of detailed, cross-setting care data – the need for which only grows in importance as health care continues its rapid transformation away from inpatient hospital care and towards outpatient medical and behavioral health settings.

**Response to Question I.3.e: “What support can CMS provide to improve states’ access to reliable and timely data?”**

Over the past six years, CMS has demonstrated significant support for APCDs through a variety of policy and financial supports. CMS quite rightly understands that APCDs increase the availability of health systems data to support innovation and problem solving in health care policy. We encourage CMS to continue the initiatives noted below and to explore additional methods to strengthen opportunities for data sharing and ongoing investments.

Maintain Access to Medicare Data Files through the State Agency Request Process and Associated Supports: The Office of Enterprise Data and Analytics has been instrumental in leading the way to enhanced access to Medicare data files through the State Agency Request process. This initiative supports state innovation projects by creating a separate request process and – even more importantly – setting file fees as low as possible. CMS has also provided important supports during the application process through its technical assistance subcontractor ResDAC. ResDAC has been very helpful in providing guidance to states on use cases, data release policy, and data sharing options. Moving forward, CMS should continue to support the State Agency Request process and maintain access to support resources for states at all stages of data request and use.

Require Medicare Advantage (Part C) plans to submit data to APCDs: Medicare Advantage (MA) plans are not required to submit claims data to CMS. While some states can and do collect MA plan data, other states note that these carriers assert exemptions from state data submission rules. CMS should clarify/affirm that state insurance regulatory authority extends to MA plans. A CMS requirement would enhance states’ ability to develop comprehensive analyses of quality by aggregating data from all payers and offering a more complete portrait of provider performance.

Clarify and align data sharing rules: With data from diverse payer sources compiled overtime, APCDs are uniquely positioned to build longitudinal views of service utilization. Properly organized and with privacy protections in place, these data can serve as the foundation for powerful analysis of the health care system. However, data restrictions on behavioral health and certain conditions (e.g. HIV) limit the sharing of data with APCDs – and, by extension, limit APCDs’ applicability to some of the nation’s most pressing current health issues, such as the opioid addiction epidemic. Medicaid agencies are often quite cautious about sharing any information at all. We recommend that CMS review health data sharing rules across all federal



health agencies to achieve consistency of rules, and to allow for sharing of these critical health data while requiring strong privacy protections.

Expand funding opportunities to sustain APCDs: States have leveraged a broad array of CMS grants and programs to explore, design, develop and implement APCDs. This financial support has been instrumental to states when launching these projects. For example, CMS funding opportunities have supported the initial development of the most recent group of APCDs getting underway:

- Connecticut and Rhode Island started with Exchange establishment grants
- Washington, Arkansas and Hawaii started with Rate Review funds
- Pennsylvania, Kentucky and New York started with SIM funds

Other states have significantly enhanced APCDs in conjunction with various CMS grant and program initiatives, including states such as Colorado, Oregon, Maryland, Massachusetts, New Hampshire, Maine, and Vermont. Many of these projects would have languished – or not started at all – without the resources provided through the CMS grant programs.

Moving forward, APCDs are challenged to find an ongoing, stable funding source that permits achieving the full vision of broad (yet appropriate and controlled) access to data. Most states with mandated data collection have a legal obligation to disseminate data to as broad an audience as possible, within established data use parameters. However, revenues from data use fees are not sufficient to cover ongoing operations costs. In fact, states often face strong opposition to a data use fee structure that represents the full cost of producing files. Even when the data are used in pursuit of multi-payer projects (including Medicare and Medicaid), the state is often required to assume the responsibility for compiling, aggregating and analyzing the data.

APCDs housed within the Medicaid agency – and directly supporting Medicaid initiatives – may qualify for federal matching funds for operating costs. A handful of APCDs currently obtain partial support in this way. In contrast, APCDs in the initial stage of development would benefit from the higher federal cost sharing for technology to defray their design and development costs. In particular, the upfront costs of creating accessible data extracts and reports are crucial next steps in the life cycle of an APCD.

CMS State Innovation projects will benefit tremendously from access to this APCD data. Fully integrated Medicaid and Medicare data in a HIPAA-compliant fashion creates important new analytic opportunities for state data users, and will enable analytic functionalities necessary for state Medicaid programs to meet federal reporting requirements, measure provider performance to evaluate payment reform initiatives, operate their programs more efficiently, and achieve Medicaid's health system transformation goals. Academic and policy analysis are further supported with access to appropriately configured research data files. Towards these ends, we recommend that CMS fund APCDs at the 90/10 technology design, development and implementation matching rate to support states' efforts to continue to make these data available as part of the Medicaid IT enterprise to support Medicaid and associated program analytics.

Support for Standardization after *Gobeille*: The US Supreme Court decision in *Gobeille v. Liberty Mutual Insurance Company* earlier this year held that ERISA pre-empts state laws mandating that self-insured plans submit data to an APCD. More than half of those individuals insured in the commercial market are covered by self-insured plans. Third party administrators have generally stopped submitting data for self-insured plans to state APCDs.

Justice Breyer's opinion in *Gobeille* suggested that the Department of Labor (DOL) could play a role in requiring ERISA plans to submit detailed claims data. Recently, DOL issued a draft rule and requested comments on what such a data collection model might consider. In response, state APCDs have come together to develop a Common Data Layout that would standardize the format and associated guidance for data submission. Related proposals suggest that DOL could partner with existing states to pilot the Common Data Layout and explore how existing APCDs would administer this. We recommend that CMS engage in this discussion, support DOL's rulemaking in this matter, and participate in the development of the Common Data Layout.

## **Conclusion**

As CMS looks ahead to supporting states in developing new innovation models, these projects must include multi-payer databases. APCDs are an opportunity to capitalize on lessons learned about data collection, aggregation and processing over the past 15 years and apply that learning to the next generation of states moving forward with thoughtful, measured and effective reforms.

**Centers for Medicare & Medicaid Services (CMS)**  
**Center for Medicare & Medicaid Innovation (CMMI)**  
**Request for Information on State Innovation Model Concepts**

**Response from the New Mexico Human Services Department  
& the New Mexico Department of Health**

The State of New Mexico received a one-year State Innovation Model (SIM) planning grant for the period of February 2015 extended through April 2016. Under New Mexico's project, the state departments of health (DOH) and human services (HSD) partnered to bring together multiple and diverse stakeholders with the goal of designing a State Health System Innovation Plan (SHSIP) that would build upon and align the many unique and cross-sector efforts already underway in the state. With a primary goal of further advancing and implementing key components of New Mexico's SHSIP, the state submits this response to the CMS/CMMI Request for Information on SIM Concepts.

In the event that CMS/CMMI indicates that additional grant funding will be made available to qualifying states under the SIM initiative, New Mexico would choose to focus on three core areas of the SHSIP:

1. **Advancing Value-Based Purchasing (VBP).** New Mexico believes strongly that alternative payment models to support VBP are fundamental to improving and ensuring quality, cost and efficiency across the delivery system. While the state Medicaid program is assertively advancing VBP initiatives in its Centennial Care program via New Mexico's 1115 waiver for 'next generation' Medicaid managed care, the state believes that engagement and alignment across payers will be necessary for broad success. Providers must be offered practice transformation tools that will help them move from the lower end of the risk continuum (e.g., provider incentives; pay-for-performance) toward greater risk-sharing and accountability (e.g., upside- risk to downside/full risk models). Funding would be used to implement practice transformation tools to support data capture and sharing; to align across payers; and to help providers achieve the payment model sophistication needed to identify, measure, evaluate and purchase value throughout the delivery system.
2. **All Payer Claims Database (APCD).** Under New Mexico's SIM planning grant, the state engaged in stakeholder deliberations and developed an APCD implementation framework. There is broad-based support for and engagement in the APCD enterprise and there is existing legislative authority to begin implementation efforts; however, the state cannot move forward quickly or effectively to implement an APCD absent additional funding. Resources are needed to execute the state's APCD Plan, in particular to specify and facilitate the use case domains and priorities, data requirements and linkages, reporting approach, administrative simplification, and information technology (IT) specifications.
3. **Medical Home Technical Assistance.** Another key idea that was identified in the state's SHSIP after broad stakeholder consultation is the provision of state-level technical assistance to smaller providers seeking to become accredited as patient-centered medical homes (PCMHs). As a rural state, New Mexico has many providers who are not affiliated with a large practice group but who are, in reality, serving the function as a PCMH without formal accreditation or recognition. Funding would be used to provide technical assistance to these providers and to give them a 'glide path' toward formal the PCMH endorsement. Similarly, New Mexico is also actively engaged in the Certified Community Behavioral Health Clinic (CCBHC) initiative, and seeks resources designed to advance CCBHC provider certification, service delivery transformation and, as stated above, a modernized and supporting payment system.

The intensive process undertaken in New Mexico funded by the SIM planning grant resulted in a detailed action plan identifying the state's priorities and approaches to affecting significant health system innovation. Additional grant funding would be focused on the components of the SIM plan outlined above. Successful implementation in these areas, particularly those related to practice transformation and value-based purchasing, will play a significant role in slowing the rate of growth of healthcare costs (one of the triple-aims) and moving New Mexico's professional practices down the path to successful participation in CMS's Quality Payment Program.



October 28, 2016

**VIA ELECTRONIC SUBMISSION**

Patrick Conway, MD, MSc, FAAP  
Deputy Administrator, Center for Medicare and Medicaid Innovation  
Chief Medical Officer, Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Dr. Conway:

Georgetown University Center for Children and Families is a nonpartisan research and policy center with a mission to improve access to affordable, comprehensive health coverage for children and their families. Thank you for the opportunity to provide input on State Innovation Model concepts. At a significant time of change in the U.S. healthcare system, the state role in testing and applying new models of payment and delivery system change is critically important, especially given the significant role states play in Medicaid.

Because children make up a significant proportion – 44 percent – of Medicaid and CHIP beneficiaries, we urge CMMI to more explicitly consider their needs as they consider a new round of state innovation model grants.<sup>1</sup> In fact, Medicaid and CHIP cover more than one-third (35.7%) of all children, nearly half (44.5%) of children under the age of six, and 82.7 percent of the most vulnerable children – those living in poverty.<sup>2</sup> While the combined purchasing power of Medicare and Medicaid provides significant leverage in driving health care quality improvements and systemic change, Medicaid in particular has a unique opportunity to be the Leader in testing child- and family-based interventions and laying the groundwork for system reforms that can pave the way for other payers.

We support and echo comments by the American Academy of Pediatrics and Learning Collaborative on Health Equity and Young Children. Since delivery system innovations and emerging payment models endeavor to revamp the health system toward the “triple aim”, an explicit focus on children is necessary given the prevention opportunities available in the younger years, where interventions can have significant impact on future success in life, particularly if primary goal is improved financial accountability for an entire state’s population. If children are not an explicit focus of payment and delivery system reform efforts, we risk overlooking models of care that can stem the tide of more complex diseases and poorer outcomes later in adulthood. Moreover, applying new models that were created primarily with adults in mind risks creating unintended complications in children’s care, which for the majority of children requires a focus upon improving primary, preventive, and developmental health

services. A focus on children requires a longer-term vision for change that can extend well into adulthood, which speaks to the need and opportunity for innovation grants.

As the American Academy of Pediatrics stated in its comments:

*The Academy urges CMMI to consider the unique needs of pediatric populations and identify payment models that reflect the unique emphasis on prevention and healthy growth and development that is the foundation [of] primary pediatric care. Only by designing a payment system with children in mind at the beginning [emphasis added] will the healthcare system produce quality care, improved outcomes and lower cost.<sup>3</sup>*

With an overarching desire to see children's unique needs elevated in state innovation models (SIMs), we offer the following recommendations for your consideration:

**Require states to devote all or a portion of funds to interventions for children.** Although nearly half of Medicaid enrollees are children, costs for children account for only \$1 in every \$5 of Medicaid expenditures.<sup>4</sup> Without explicitly dedicating a share of SIMS funding to advancing pediatric services, the trend in delivery system reform focusing on areas where there are greater savings opportunities is likely to continue. Many states are working to improve developmental screening and interventions, address infant and early childhood mental health, and home visiting—all strategies that can address the primary, preventive and developmental needs of children. A perspicuous focus on payment and delivery models for children could help to test and spread best practice models that consider the full system of supports children need. For example, in New York, a United Hospital Fund report highlighted areas of need in fully addressing value and measuring quality for children's health as part of reform efforts.<sup>5</sup> The report found that there is scant evidence of emerging value-based purchasing (VBP) models focused on children, despite discussion of ongoing efforts to improve pediatric services in a variety of delivery systems. Bailit Health, led by the United Hospital Fund and the Schuyler Center for Analysis and Advocacy, recently conceptualized a possible value-based payment model for children based on New York data that could be applied and tested in other states.<sup>6</sup>

**To ensure children's needs are explicitly addressed, require states to adopt the AAP Bright Futures guidelines and report CMS child core set measures as a condition of a SIM grant.** The American Academy of Pediatrics Bright Futures guidelines were the recognized standard for pediatric care long before it was systematically adopted by the Affordable Care Act, yet not all states fully adopted its periodicity schedule or practice recommendations as a condition of Medicaid payment. As an evidence-based foundation for preventive and primary care services for children, Bright Futures should be the starting place for any system redesign and a requirement for SIMS states because it addresses children's unique needs.

Additionally, for any multi-state or federal-state alignment effort to be effective, strong outcome and quality data will be necessary. The Children's Health Insurance Program Reauthorization Act of 2009 created the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP that states may report voluntarily. Most states reported at least half of

the core set measures for 2014, but only two states reported the full set. While the core set is a limited collection of health outcomes for children, its ongoing stakeholder input and vetting process allow for measures to evolve overtime. Reporting the full core set is an important first step for any cross-state or federal-state alignment efforts toward quality improvement or system changes. Requiring SIM states to report the full child core set would also accelerate a better understanding of their utility in practice, serving as a model for other states and informing the ongoing stakeholder input and vetting process that allows for core set measures to evolve overtime.<sup>7</sup> While the core set should serve as a baseline for quality data collection and reporting, SIM states should also be encouraged to develop additional screening tools and health outcome metrics which address social as well as bio-medical determinants of health to accelerate attention on preventive and developmental responses to children.

Thank you for your consideration of these recommendations. Please feel free to contact Elisabeth Wright Burak ([elisabeth.burak@georgetown.edu](mailto:elisabeth.burak@georgetown.edu)) with any questions.

Sincerely,

Joan C. Alker  
Executive Director

<sup>1</sup> Centers for Medicare and Medicaid Services. Office of the Actuary (2015). 2015 Actuarial Report: The Financial Outlook for Medicaid. <https://www.medicaid.gov/medicaid-financial-report/downloads/medicaid-actuarial-report-2015.pdf>

<sup>2</sup> Georgetown Center for Children and Families analysis of U.S. Census 2015 American Community Survey data. Also see <http://ccf.georgetown.edu/wp-content/uploads/2016/07/Childrens-Medicaid.pdf>

<sup>3</sup> American Academy of Pediatrics letter to Patrick Conway, October 19, 2016. /s/ Bernard Dreyer, President.

<sup>4</sup> *op cit* (1).

<sup>5</sup> See Brundage, S. (2016). You Get What You Pay For: Measuring Quality and Value-Based Payment for Children's Health Care. New York, NY: United Hospital Fund, available at <https://www.uhfnyc.org/publications/881134>

<sup>6</sup> Bailit Health (2016). Value-Based Payment Models for Medicaid Child Health Services. <http://www.uhf-nyc.org/publications/881145>

<sup>7</sup> U.S. Department of Health and Human Services (2016). 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP. HHS: Washington, D.C. <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf>



October 28, 2016

Centers for Medicare & Medicaid Services  
U.S. Department of Health & Human Services  
[SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov)

To Whom It May Concern:

The National Committee for Quality Assurance (NCQA) would first like to thank you for the opportunity to comment on your Request for Information on State Innovation Model Concepts. We believe working directly with states to expand payment and delivery reform at the state level is a highly effective approach that can leverage public payer leadership to accelerate multi-payer alignment and health care transformation on a wide scale.

NCQA generally agrees with all objectives laid out in the RFI. We particularly support implementing models that could qualify as Advanced Alternative Payment Models (APMs). APMs not only have greater ability to improve quality because of their sophisticated structure, they are subject to financial risk and therefore also have strong incentives to do so without increasing costs.

#### **Multi-payer State Based Strategies for APMs**

Access to data has and will remain an immediate obstacle to any multi-payer alignment efforts. For example, self-insured payers are reluctant to share data on their enrollees. Partially or fully self-insured plans cover as many as [92 million lives](#) according to Kaiser Family Foundation – an effective multi-payer strategy must address the issue with these plans. Behavioral health providers are often similarly reluctant to share patient data. Although it may not be feasible to compel these stakeholders to share certain data, federal authorities can develop models that offer incentives to do so.

Another challenge is that many payers have already invested significant dollars in quality improvement and payment reform. Before implementing a new standardized care intervention, states must first talk to each other and the payers in their markets to reach consensus about an APM that would both be of interest and also be accepted by Medicare. The Health Care Payment Learning & Action Network is a great example of information sharing and is a model for future collaboration across states.

Securing multi-payer participation is contingent upon incorporating existing efforts. For example, because of Star Ratings, Medicare Advantage plans have long-standing incentive structures and risk agreements in place that drive substantial portions of their revenues. Many Medicaid programs have also invested heavily in bundled or global payment initiatives. Any national alignment effort would need to acknowledge these as well as commercial payer models for those plans and clinicians that participate in both public and private programs. This would mitigate the risk of conflicting payment models that generate cross-purpose incentives and also ensure that MCOs remain financially viable. Similarly, models must be flexible enough to ensure that model participants can meet the needs of their specific populations. For example, commercial insurers within Tennessee's public employee benefits program



were unable to participate in the state's SIM initiative because that particular model was so heavily focused on Medicaid.

Addressing these challenges and others will be critical to the success of multi-payer delivery system reforms. However, there are several other factors to consider as well:

- **Patient-centered design:** Models must put patient safety, outcomes and experience at the forefront of delivery reform.
- **Core set of quality measures:** There should be consistent quality measures across payers, specified to the unit of accountability, applicable to both primary and specialty care, that can be used to facilitate apples-to-apples comparisons. Consistency also reduces the reporting burden on clinicians.
- **Technical assistance and support for practice management infrastructure:** Financial and technical support for care management platforms and other workable health IT solutions will be critical to both the success of a model and the participating clinicians. An agreed-upon health information exchange is essential, with additional support provided to practices looking to begin electronic clinical data reporting. Models should require audited oversight to ensure the integrity of the data and the accuracy of reporting prior to attaching payment to performance. Tools that analyze data on claims and gaps in care and also generate actionable feedback to clinicians would be similarly helpful. Especially on cost measures, clinicians need more robust performance reports to identify areas for improvement.
- **Risk adjustment:** NCQA does not support the risk adjustment of clinical quality measures for sociodemographic factors. We do however support adjusting payments to clinicians to account for the greater resources needed to care for complex patient panels. Adjusting the measures themselves would merely hide without addressing gaps in quality – especially among more disadvantaged and complex Medicaid populations.
- **Transparent benchmarking:** Transparent, agreed upon benchmarking methodologies will be helpful for all clinicians. These are particularly critical however for small and rural practices that may have less control over the total cost of care. Consensus on methodologies that promote accountability for lowering the cost of care will also encourage the kind of collaboration among clinicians that's necessary for improving patient outcomes.

Medicaid programs face their own unique challenges in addition to those discussed above. Constant shifts in eligibility and enrollment impact the ability to uniquely identify patients across the continuum of care. This in turn makes it difficult to manage the care provided to Medicaid beneficiaries and fairly attribute each member to a clinician. Outdated state systems add to these challenges – limitations in data collection result in some states only measuring what is easy to measure because their systems are currently unable to collect anything else.

Social factors that influence health tend to have a greater impact on this population as well, resulting in greater incidence of chronic comorbidity and greater challenges in adherence to medications and care plans. These factors are especially pronounced in rural areas in states with limited access where fair comparisons of patient outcomes may be difficult to achieve.

To get an accurate evaluation of readiness and continued transformation toward patient-centered care, we recommend using a consistent practice assessment tool. Standardized models such as NCQA Patient-

Centered Medical Home (PCMH) and Patient-Centered Specialty Practice (PCSP) could provide the desired consistency.

For example, the State of Vermont Blueprint for Health used NCQA PCMH as a multi-payer standardized measure of practices' capability to provide advanced primary care. This provided the necessary foundation for those practices to participate more broadly in reform efforts through State Innovation Model testing.

The basic tools and technical assistance listed above are the foundational elements that CMS can support for states launching multi-payer reforms. To reiterate, there must be an emphasis on health IT. New support for building health information exchanges and analytics engines will facilitate regional exchange and processing of clinical quality data; this should be the linchpin of any sophisticated delivery reform effort. Usability testing of these solutions is also necessary to ensure they can be effectively integrated into clinical workflows. CMS could further bolster this effort by requiring public reporting of scoring to drive faster innovation and improvement in usability and interoperability.

Meaningful evaluations will be important for measuring the efficacy and extent of new delivery reform models. However, such evaluations are contingent upon several factors that must be built into a model itself to ensure accuracy and fairness. These factors include risk stratification models, appropriate risk adjustment to payment, consistent measures for each population as well as consistent methodologies for data collection, calculation and reporting. Each process should also be audited, either through certification or other third party methods to ensure data integrity.

We encourage CMS to emphasize patient-reported outcomes measures as a way to improve the fairness of evaluations. However, we do have concerns about using statewide survey data, such as CAHPS, to measure outcomes in a model. Although it may be expedient, it could potentially disconnect measurement from accountability because the results may not be sufficiently timely or actionable for individual facilities or clinicians. We believe you should incorporate ways to measure outcomes that provide actionable results that can in turn be used for care processes, quality improvement, and accountability.

We also recommend special consideration for safety net facilities and practices that may need more support to accommodate their unique circumstances.

### **Total Population Health**

Achieving accountability for total population health will require all of the tools and resources listed above and more. Again, this includes special focus on technical and financial support for robust care management platforms as well as data extraction processes. Care management fees provide a good foundation but CMS should provide resources specific to total population health. NCQA PCMH and PCSP standards provide the necessary infrastructure for practices looking to assume this kind of accountability and incentivizing NCQA recognition could help ensure that practices are actually prepared to do so. The Medicare Access and CHIP Reauthorization Act (MACRA) recognizes our programs as meeting national standards for Clinical Practice Improvement. This is an ideal opportunity to create alignment across programs by encouraging use of a single standard like NCQA PCMH to meet a specific goal such as total population health accountability.

Again, general health IT adoption and use to improve care must also remain a top tier priority. However, rather than tie financial incentives to adoption, it may be useful to incentivize progress on the specific features of health IT. For example, usability and interoperability are not evolving at an adequate pace.

MACRA includes provisions that encourage progress in these areas but incentives at the state level could provide an additional policy lever to catalyze further development.

For example, you could incentivize development of platforms that enable hospitals to send real-time admission alerts to care coordinators. You could further incentivize clinicians themselves to actually use those systems to coordinate follow-up care.

We encourage CMS to offer support for all-payer claims databases and alignment of data structures for the purpose of supporting attribution models as well as quality and cost measure calculations. It will be important, however, to standardize data access rules as these rules currently differ across states. We also believe it's important to address the challenges in getting data from health plans to any kind of integrated database. Third party certification should be used to verify the integrity of the source data before it's integrated into any such database.

For population health measures, we again encourage use of patient-reported outcomes. Vital Signs and Patient-Reported Outcomes Measurement Information System are great resources for patient-centered measures that monitor physical, mental, and social health. These will offer the kind of whole-person assessment that will be critical for accurately measuring outcomes.

Another area of opportunity is behavioral health where privacy rules limit data sharing. We encourage CMS to work more closely with SAMHSA to outline the types of data that can be shared across clinicians to encourage more care coordination. Specifically, we encourage you to provide further clarification on the 42 CFR Part 2 regulations that dictate substance abuse confidentiality. Behavioral health is a critical aspect of patient outcomes and lack of clarity around data sharing rules remains a major obstacle for care coordination between primary and behavioral health care providers.

### **Assessing the Impact of Multi-State Care Interventions**

It is our experience that states are willing and excited about participating in new delivery and payment initiatives. It will be important, however, for states and the payers in their markets to come to consensus on a model that is both appealing and rigorous enough to qualify as an Advanced APM under MACRA. Vermont is an example of a state that leveraged Medicaid authority to test the impact of statewide multi-payer support for patient-centered medical homes. The Vermont PCMHs have lowered annual health care expenditures by as much as \$450 per patient.

Another area of opportunity is in addressing disparities, as noted in the recently updated Medicaid Managed Care Rule. Effective models to address disparities should include extensive, mandatory data collection and use imputation strategies where data availability lags. Stratified reporting of that data will help identify specific drivers of regional disparities and the corresponding payment model can provide adjustments to account for those complexities. Plans and clinicians will need assistance with implementation so the model should also provide technical assistance.

NCQA developed a set of standards for plans and community based organizations delivering Managed Long-Term Services and Supports (MLTSS) and these could be used for models specific to addressing disparities. This accreditation program addresses the unique needs of individuals receiving LTSS in the home and community, including the non-medical supports necessary to provide well-coordinated, comprehensive care. Requiring this accreditation for programs such as the Financial Alignment Demonstrations could offer the alignment and standardization that is critical to a model's success.

States can leverage External Quality Review Organizations to focus on quality improvement specific to mitigating health disparities. Such an approach should implement person-centered care processes and

evaluate beneficiary experience through patient engagement in all relevant languages. Collaboration with community health organizations can help engage people who may be difficult to reach. The NCQA Multicultural Health Distinction is an accreditation option for organizations to distinguish themselves as meeting the Office of Minority Health Culturally and Linguistically Appropriate Services Standards.

Another challenge to consider is that Medicaid beneficiaries often cycle in and out of eligibility. Tracking and coordinating care for this population across the care continuum is therefore difficult. Direct facilitation of all-payer claims databases and health information exchanges could mitigate some of those tracking issues.

Finally, we would like to praise your efforts at implementing sophisticated multi-payer alignment models such as Comprehensive Primary Care Plus. Continuing to do so will encourage greater collaboration between payers and help clinicians prepare to participate in Advanced APMs. Future patient-centered models should test interventions such as behavioral health integration and also focus on fostering community linkages that can help address the social determinants of health.

Thank you for the opportunity to comment on this Request for Information. We look forward to working with CMS and the Innovation Center as you develop new priorities and new models for health care payment and delivery. Please contact Kristine Thurston Toppe at 202-955-1744 or [toppe@ncqa.org](mailto:toppe@ncqa.org) if you have any questions.

Sincerely,

Margaret O'Kane  
President



October 28, 2016

Mr. Andy Slavitt

Acting Administrator

Centers for Medicare and Medicaid Services

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Dear Mr. Slavitt:

AMGA welcomes the opportunity to comment on the "Request for Information on State Innovation Model Concepts." AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups participate in many if not all Alternative Payment Models (APMs) including the Medicare Shared Savings Program (MSSP), the Pioneer and Next Generation Accountable Care Organization demonstrations, the two, soon to be three, bundled payment demonstrations, as well as in several other CMS demonstrations including the Comprehensive Primary Care (CPC) demonstration and the CPC+ demonstration. Therefore, AMGA has a strong interest in CMS continuing to support state efforts to develop and align multiple payers in Medicare APM arrangements.

In the nine-page State Innovation Model (SIM) Request for Information (RFI), CMS states, in part, the agency is generally interested in learning "ways to support broad payer and health care provider participation in alternative payment models." The RFI states further, "CMS invites comments on concepts for a future state-based initiatives that would support states to implement broad scale, multi-payment delivery and payment reforms." CMS is interested in pathways that would align Medicaid and private payers around an existing Medicare care model or demonstration. CMS also, among other things, seeks ways for states to leverage their role to reduce health care disparities across vulnerable populations.

Summarized, the comments below are based largely on RTI's evaluation of the SIM initiative. RTI's findings to date suggest there are substantial opportunities to target or better target future SIM programming in these five areas.

#### 1. Accountable Care Organizations (ACOs)

The SIM RFI is interested in states aligning "Medicaid and private payers around one or more existing CMS models and initiatives," for example, the ACO program and demonstrations. According to the Center for Health Care Strategies, there are currently 10 states with Medicaid ACO programs

And six more states actively pursuing them. However, it appears from the RTI's evaluation employers or self-insured employers in SIM states are not engaged or widely participating in APMs or in state SIM programming. RTI stated in its August 2016 evaluation in Arkansas Walmart participates in the state Primary Care Medical Home (PCMH) and Episode of Care (EOC) models and has actively been encouraging other employers to participate. In Minnesota, RTI characterized employer involvement by quoting a stakeholder who commented, "It is my impression that . . . fully-insured employers . . . don't really know what is going on [regarding SIM programming]." We note this disconnect because several employers are contracting directly with ACO organizations, most notably Boeing. Beyond ACO contracts in Washington, Missouri and South Carolina, this past June the Boeing announced it is making available to its 15,000 southern California employees and dependents ACO care via a contract with Memorial Care Health System. Additionally, companies such as United Airlines, Lowe's and Walmart are also contracting directly with other APM model providers, for example, under bundled payment arrangements. AMGA encourages CMS to use future SIM funding to support state efforts to better align self-insured employer plans with APM programming.

CMS is scheduled to announce its Accountable Health Communities (ACH) demonstration participants before the end of this year. As noted in the AHC announcement, ACH's are designed to "bridge the divide between the clinical health care delivery system and community service providers to address . . . health-related social needs." Citing again the RTI evaluation, a few states, it appears Minnesota and Massachusetts principally, are working to integrate primary care with other health and social services, including behavioral health services and long-term services and supports and perhaps eventually to become next generation integrated health plans where social service organizations would participate in accountability for the total cost of care in a population and earn portion of any shared savings. AMGA encourages future SIM funding support the expansion of the agency's ACH work.

## 2. Disparities

As noted above, the SIM RFI states, "CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations." Per RTI's SIM evaluation there appears to be little or no attention to date by states to address disparities. The only activity noted appears to be Oregon's effort publish on its website state-level reports on racial and ethnic disparities. Considering the lack of progress in reducing healthcare disparities, CMS should prioritize reducing disparities in future SIM funding. For example, the Agency for Healthcare Research and Quality (AHRQ) 2015 "Health Care Quality and Disparities Report" found poor households and minorities received worse care than people in high-income households and whites by 60 and 40 percent respectively,

### 3. Marketplaces

Over the past few months there has been considerable discussion or debate concerning the performance or stability of the Affordable Care Act (ACA)-created state insurance marketplaces. Again, per RTI's evaluation there appears to be little effort to use these marketplaces to further the goals of the SIM initiative. RTI did find that in Arkansas, the state has used marketplace policy levers to mandate PCMH participation among qualified health plans (QHPs) and Medicare Advantage (MA) Special Needs Plans (SNPs). AMGA believes the state marketplaces offer substantial opportunities to further the goals of the SIM initiative, particularly aligning state payers with APMs.

### 4. Medicare Advantage

On October 25, the Health Care Plan Learning Action Network (HCPLAN) released a report titled, "Measuring Progress." The report found, in part, 23 Medicare Advantage plans representing 9.6 million lives, or 57 percent of the Medicare Advantage market, reported that 41 percent of their 2016 spending was tied to APMs defined in either HCPLAN's category three or four. That means payments tied to upside gain sharing, downside risk, condition specific care or population based care. (The HCPLAN authors did recognize self-reporting may have biased their findings.) We note because, again, the 2016 RTI evaluation appears to show MA participation in the SIM initiative is minimal. RTI noted in Arkansas there is, again, some coordination between MA SNPs and the state's PCMH programming and in Oregon via some interaction with the state's Care Coordination Organizations (CCOs). If MA participation in APMs is as substantive as the HCPLAN survey suggests, there appears to be substantial opportunity for states to more fully partner far with MA via the SIM initiative.

### 5. PACE

In the CMS SIM memo, "Areas for Medicare Alignment in Multi Payer Models under the State Innovation Models Initiative," the agency states, "a basic tenet of SIM is the belief that State governments can play a key role in coordinating efforts among payers and providers in their State." This statement is particularly relevant to Medicare PACE (Program for All-Inclusive Care for the Elderly), as its programming is contingent upon state Medicaid agency approval. Because the PACE care model:

- is substantially under-utilized, 18 states do not offer PACE and the program provides care for only approximately 35,000 beneficiaries;
- not being exploited by any SIM state or no SIM state is focused on the PACE population, i.e., the multi-comorbid frail elderly with particularly high rates of cognitive impairment (there is no mention of PACE in RTI's evaluation work); and,
- no longer requires PACE providers to be not-for-profit, i.e., there are for profit providers interested in providing PACE care;

for these reasons and others, CMS should exploit the SIM initiative to realize far wider adoption of PACE or PACE-like care in SIM states.

## 6. Specific Care Interventions Across Multiple States

CMS states in the SIM RFI the agency is interested in “assessing the impact of specific care interventions across states.” “States would forego the flexibility of varying the intervention,” CMS states further, “so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.”

AMGA questions this approach. Attempting to spread, or as is commonly termed “spread,” a specifically defined intervention across multiple states makes certain assumptions about the nature of research innovation and how innovation in the practice setting occurs. “Assessing the impact of a specific care intervention across states” assumes knowledge is first produced and then disseminated. That is new knowledge, here a clinical practice improvement, is a “thing” or an “it” that transfers like money from one person to another. Improving patient care simply becomes, as Don Berwick argued in 2005, a re-engineering effort to drive out variation or bring to ever larger scale uniform care delivery improvement. (See: Don Berwick, “The John Eisenberg Lecture: Health Services Research as a Citizen in Improvement,” Health Services Research (April 2005): 317-336.) Healthcare delivery, in sum, becomes manualized.

Unfortunately, as Martin Wood and others have persuasively argued, knowledge of a clinical practice improvement is rarely preformed, pre-existent or self-evident. (See, for example, Wood, et al., “Achieving Clinical Behaviour Change: A Case of Becoming Indeterminate,” Social Science and Medicine (198): 1729-1738.) The improvement is not, per Wood, “situated knowledge,” not meaning independent. Healthcare providers do not simply “apply disembodied scientific research to the situation around them.” They interpret and [re]construct its local validity and usefulness.” (Science determines only the strength of the evidence that exists for any particular hypothesis. It does not presuppose a purpose or end. That’s teleology.) If this were true reasons would be causes. If this were true all clinicians at all times would practice appropriate hand hygiene.

Atul Gawande's 2004 profile of Dr. Warren Warwick's success with his cystic fibrosis patients serves as an excellent example of Wood's argument. (See: Atul Gawande, “The Bell Curve,” The New Yorker, December 6, 2004.) Warwick's practice is primarily relational. While Gawande illustrates Warwick's success for other purposes, he does describe in detail Warwick's ongoing back and forth interactions with his patients. He focuses on Warwick's interaction with a particular young female during which Warwick tries to make sense of the patient's reduced lung capacity by persisting in asking her about coughs, colds, treatment frequency, etc. Eventually, Warwick learns the patient has a new boyfriend and job and for these reasons she had been skipping her treatments. Learning this, Warwick is now able to work out an agreed-upon, meaningful and effective treatment plan with his patient to reverse her functional decline. Warwick's approach is patient-specific, it is not a “specific care intervention.” It cannot be simply spread or tested in multiple states. Not surprisingly, Gawande notes Warwick is disdainful for clinical guidelines that he tells Gawande are, “a record of the past and little more.”



As Thomas Kuhn noted in his famous work, The Structure of Scientific Revolutions, there is no research absent a conceptual paradigm. Here, the paradigm is new knowledge, again a discrete "thing" or "it," is first obtained and then, being self-announcing or context free, is mechanistically and linearly transferred from one person or organization to another. This is the commonly expected paradigm, or in Kuhn's terms is, "normal science." This explains why the Agency for Healthcare Research and Quality (AHRQ) terms its dissemination work "knowledge transfer" and manages a "knowledge transfer program" (at: <http://www.ahrq.gov/cpi/centers/ockt/kt/index.html>). This approach, this paradigm, has proven to be ineffective. For example, AHRQ's own Evidence Report (#213) regarding dissemination published November 2013, notes at pages ES 8 and 9, the "strength of evidence" for dissemination strategies commonly used by AHRQ is moreover "low" or "insufficient." AMGA believes "assessing a specific care intervention across multiple states" is inherently, if not fatally, flawed. AMGA encourages CMS to take a more sophisticated view of how innovation occurs in, or across, clinical practice settings.

Thank you for your consideration of our comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at [dintrocaso@amga.org](mailto:dintrocaso@amga.org) or at 703.842.0774.

Sincerely

Donald W. Fisher, Ph.D.  
President and CEO



Planned Parenthood  
Federation of America



Planned Parenthood Action Fund

October 28, 2016

VIA ELECTRONIC SUBMISSION

Patrick Conway, MD, MSc  
Deputy Administrator for Innovation and Quality  
Center for Medicare and Medicaid Innovation  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Request for Information – State Innovation Model (SIM) Grants**

Dear Dr. Conway:

Planned Parenthood Federation of America (“Planned Parenthood”) and Planned Parenthood Action Fund (“the Action Fund”) are pleased to submit these comments in response to the September 8, 2016, Request for Information (RFI) concerning State Innovation Model (SIM) grants. We appreciate CMS/CMMI’s effort to obtain stakeholder input on potential state-based initiatives to test payment and service delivery models designed to improve the quality of health care while reducing Medicare and Medicaid expenditures. The SIM program continues to hold promise to drive important innovations, and we believe this is a critical moment for CMS/CMMI to turn its attention to areas not addressed in previous rounds of grant-making, specifically innovations in the delivery of women’s health care.

Planned Parenthood is the nation’s leading women’s health care provider and advocate and a trusted, nonprofit source of primary and preventive care for women, men, and young people in communities across the United States. Each year, Planned Parenthood’s approximately 660 health centers provide affordable birth control, lifesaving cancer screenings, testing and treatment for STDS, and other essential care to nearly three million patients. We also provide abortion services and ensure that women have accurate information about all of their options.

Across the country, Planned Parenthood affiliates are leveraging health care sector innovation to improve access to quality care for women of reproductive age. The comments below suggest a

Path forward for CMS/CMMI to transform Medicaid payment and delivery in ways that can improve quality and patient satisfaction, while potentially reducing costs for women of reproductive age.

## **I. The Next Round of SIM Grants Should Give States Resources and Tools to Improve Access and Quality for Women of Reproductive Age.**

The Affordable Care Act (ACA) has greatly expanded low-income women's access to care by financing Medicaid expansion in 32 states so far, creating a new state option for family planning, and subsidizing private insurance coverage through health insurance exchanges in all states and territories. Despite these advances, affordable high-quality reproductive health care services remain out of reach to many women. Eleven million women still lack insurance coverage.<sup>1</sup> Overall, because of structural barriers to care, health inequities among women persist in outcomes and access across race, ethnicity, geographical regions, income and education.<sup>2</sup>

At the same time, transformational initiatives have been dominated by priorities for Medicare payment reform, with less focus around the alignment of payment systems in the private sector. Indeed, to date, many of CMMI's premier programs are focused on Medicare populations and needs—such as the advanced and comprehensive primary care practice demonstrations and the first two rounds of SIM grants, which focus on delivery strategies for older people, people with multiple chronic illnesses, and people living with disabilities.

In this context, SIM Year 3 is an opportunity for CMS/CMMI to rebalance the innovation portfolio to ensure transformation accounts for high-value primary care and prevention for younger people who rely on Medicaid and safety-net health care, especially women of reproductive age. In particular, investments are needed to incentivize integration of reproductive health and build capacity to develop and sustain innovative patient-centered health care delivery to women of reproductive age.

### **A. SIM Investments Should Incentivize States to Integrate Patient-Centered Reproductive Health Care in Delivery and Payment Innovation.**

The RFI asks for comment “on specific care interventions for which additional evidence is required” that would benefit from a SIM approach. We believe that CMS/CMMI should test a care coordination model for women of reproductive age.

<sup>1</sup> Health Insurance Coverage of Women 19-64. Kaiser Family Foundation. <http://kff.org/other/state-indicator/nonelderly-adult-women/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>2</sup> Disparities in Health and Health Care: Five Key Questions and Answers. August 2016. <http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers>

Reproductive care is at the center of what many women need to stay healthy, according to the most recent guidelines.<sup>3</sup> Research shows that low-income women tend to think of reproductive health care providers as their primary (or only) source of care. They are pivotal entry points to the broader health care system and connector to other care and services, including behavioral health and social supports. Reproductive health providers offer comprehensive family planning services and critical preventive care screenings and interventions, serving as primary care providers for women of reproductive age. Women report that they are 16 percent more likely to be open and honest with reproductive health providers over other providers.<sup>4</sup> and trust in a provider has been connected to improved health outcomes.<sup>5</sup>

Given the comprehensive nature of the services and supports provided, reproductive health providers can fulfill evaluable coordination role in Medicaid programs that serve non-dual populations. Yet under care coordination models developed to date, care is delivered and coordinated by primary care entities under restrictive definitions of “primary care.” For adults, primary care providers are being defined almost exclusively as family practice and internal medicine providers. For example, in the NCQA patient centered medical home (PCMH) model, reproductive health providers like Planned Parenthood cannot be designated as PCMHs.

Models like the NCQH PCMH model, adopted as a one-size-fits-all approach, do not take into account the unique needs of women, particularly women of reproductive age. Almost 6 in 10 women (58 percent) report seeing an OB/GYN on a regular basis and one-third of women (35 percent) view their OB/GYN providers their main source of care.<sup>6</sup> the exclusivity of the PCMH model in new delivery systems means that many women do not have access to a medical home that meets their needs.

CMS/CMMI should invest in the development of alternative care coordination models for key Medicaid non-dual populations whose needs are not met through strict PCMH structures. The Strong Start program, which includes a “maternity care home” to help improve birth outcomes, could be explored as a foundation. An expanded model, for all women of reproductive age, would serve to recognize in a broader sense that women have different health care needs and rely on a different set of providers than other populations served by public programs. It would also serve to reflect the unique needs and care-seeking styles of Medicaid’s younger, healthier women—especially with respect to reproductive health, contraceptive choice, and care coordination. This model could serve the broader goals of reducing unnecessary costs to the system, while advancing CMS’ own stated goals of increasing access to the full range of contraceptive methods, including long-acting reversible contraception (LARC).

<sup>3</sup> Well Woman Care: Assessments & Recommendations. The American College of Obstetricians and Gynecologists. July 16, 2013. <http://www.acog.org/-/media/Departments/Annual-Womens-Health-Care/Pri maryAndPreventi veCa re.pdf>.<sup>4</sup> PerryUndem Research & Communication. “Women & OB/GYN providers”. Research conducted for Planned Parenthood Federation of America, November 2013.

<sup>5</sup> Hall, Mark A., L. Gregory Pawlson, and David H. Thom. (2004). “Measuring Patients’ Trust in Physicians When Assessing Quality of Care.” *Health Affairs*. Vol.23, No. 4, p. 124.

<sup>6</sup> PerryUndem Research & Communication. “Women & OB/GYN providers”. Research conducted for Planned Parenthood Federation of America, November 2013.

## **B. SIM Investments Should Increase System Capacity to Deliver High-Quality Integrated Care for Women of Reproductive Age.**

The RFI asks for input on “factors essential to the success of multi-payer delivery system reforms.” We believe that appropriate delivery reform for women of reproductive age cannot be achieved without capacity building investments, similar to how investments have been essential in efforts to improve quality and patient experience for other populations. The next round of SIM investments should include a focus on expanding the capacity of safety net reproductive health care providers, as a part of developing innovative care models for women and supporting reproductive health providers’ successful engagement in payment models that provide the highest quality care for their patients. Examples of appropriate capacity-building efforts are offered below. These include development in the areas of technology, workforce, and telehealth.

*Technology and Support Systems to Undergird Coordinated Care.* It has long been acknowledged that health information technology and related support systems have the potential to improve access, health outcomes, and patient experience. Further, patient-centered delivery innovation requires ever more sophisticated capabilities at the provider level. To participate, community-based reproductive health providers need expanded capacity to manage data, appropriately connect with external parties, and undertake quality measurement and reporting activities.

*Staffing to Coordinate Care.* As discussed above, women access reproductive health providers as their primary or only source of care, and these providers serve as pivotal entry points to the broader health care system, including behavioral health and social supports. To test innovative patient-centered approaches to their care, having the appropriate workforce in reproductive health settings will be critical. Investments in model development should include sufficient amounts to build and sustain staff capacity for new administrative requirements, as well as direct services such as care coordination.

*Telehealth.* Expanded access to care and facilitating better care coordination through telehealth holds great promise for women of reproductive age. In fact, interest in leveraging telehealth for women of reproductive age is growing. For instance, the telehealth provider American Well found that 42 percent of women age 18-34 are interested in accessing birth control from a provider online. And public and private organizations are beginning to fund telehealth services for younger women: The VA has invested in telehealth services for women veterans in rural areas, and in April 2015, venture capitalists invested \$2.2 million into the mobile platform, Maven, aimed at women of child-bearing age. There is a real opportunity to ensure that telehealth innovations also serve low-income women of reproductive age, which would help to improve access and outcomes. To make progress towards that end, it is important to consider capacity building investments for telehealth programs operated by safety net reproductive health providers.

## **II. The Next Round of SIM Investments Should Test Alternative Payment Models That Incentivize Delivery of Preventive Services and Care Coordination Leading to Better Outcomes for Women Over Time.**

The RFI asks for input on “core delivery and payment reforms [that] can include accountability for the health outcomes of a population.” We believe that new models accounting for the impact of preventive care need to be developed.

Much of SIM and other CMS innovation programs have been centered on payment approaches that focus on total cost of care with a baseline/benchmark approach. These approaches, reflected in demonstrations of accountable care organizations (ACOs) and comprehensive primary care entities, are designed for high-cost populations for whom care coordination will improve outcomes and lower costs in relatively short timeframes, typically annually.

Going forward, those important initiatives should be balanced with programs that focus on longer term savings and health outcomes improvement. For women of reproductive age, that means focusing on building innovative care models that meet their unique health care needs. CMS/CMMI should consider investments that build on the role of reproductive health providers and the services they offer. For instance, CMS/CMMI should consider programs that support reproductive health providers in their efforts to help women avoid unintended pregnancy; fulfill a care coordination role that is appropriate, patient-centered, and culturally competent for women of reproductive age; and prevent acute and chronic illnesses that manifest in the medium- and long-term and are costly to treat over time.

*Unintended and unwanted pregnancy.* Contraceptive care is a key component of improving health in women and children. Around half of pregnancies are unintended each year, and reducing this rate has been shown to improve maternal outcomes and reduce incidence of low birth weight and premature birth. Further, an estimated \$7 is saved for every \$1 invested in family planning services.<sup>7</sup> Value-based payment models should not only account for the value of contraception in reducing and avoiding health care costs; payers should also be incentivized to adopt payment models that properly attribute these outcomes as a part of meeting the goals of system change.

*Care coordination.* Patient-centered, culturally competent care coordination is integral to high-quality care for women of reproductive age. As noted above, reproductive health providers fulfill a critical role in coordinating patient-centered care for women of reproductive age, in addition to meeting their family planning needs. Women access reproductive health providers as their sole or primary source of health care, including information and referral to specialty and behavioral health care and needed community supports. Payment and delivery reform should build on this relationship by supporting care coordination models that are centered with reproductive health providers.

<sup>7</sup> Guttmacher Institute. “Publicly Funded Family Planning Services in the United States.” (Mar. 2016). <https://www.guttmacher.org/fact-sheet/2015/publicly-funded-family-planning-services-united-states#15>

*High-Impact Preventive Services to Women.* Reproductive health and other preventive services lead to positive health outcomes for women across their lifespans. These services include screenings for cervical and breast cancer, screening and counseling on smoking and weight, behavioral health screening, and testing for chlamydia, HIV, and other STIs. When women have access to these services, provided in a culturally competent manner in their communities, early intervention is enabled, poor outcomes are averted, and the health care system achieves considerable savings overtime. Value-based payment models in use or in development today generally do not calculate the full value of these impacts to the system, nor do they accurately account for the costs of providing this high-quality care.

Current shared savings models based on total cost of care (TCOC) in particular are often unable to accurately pay for prevention. For example, in Vermont's Shared Savings Program, an ACO agrees to serve a population of Medicaid patients on a fee-for-service basis, as well as coordinate patient care among member providers. In exchange, the ACO is eligible for a "shared savings" payment based on whether the total actual cost of care provided by the ACO for their population is lower than the states expected total cost of care. Savings and costs are calculated on an annual basis, using historical costs as a benchmark. As a result, this model incentivizes only those services that could result in short-term cost savings captured within a 12-month window.

An entirely new value-based approach is needed to account for delivery of preventive services, like reproductive health care, that have cost impacts over a lifespan, or at least considerably longer than a year. Some evidence is available to craft new methodologies, and more evidence needs to be developed. For instance, recent estimates show that tobacco cessation programs have a \$2-3 return on investment, in addition to improving health outcomes. An accountable care entity should be incentivized to pursue preventive strategies that have long-term impacts on health status and costs to the system. The payment model should also recognize the total costs of maintaining system capacity to deliver patient-centered, culturally competent preventive care for all.

In conclusion, we thank you for the opportunity to provide input into the transformative work of CMS/CMMI, and look forward to working with your office to advance a payment and delivery reform agenda to meet the needs of women of reproductive age. If you have any questions, please do not hesitate to contact me at 202-973-4800.

Sincerely,

Dana Singiser  
Vice President of Public Policy and Government Relations  
Planned Parenthood Action Fund  
Planned Parenthood Federation of America  
1110 Vermont Avenue NW, Suite 300  
Washington, DC 20005



October 28, 2016

The Honorable Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
P.O. Box 8013  
Baltimore, MD 21244-8013

Dear Acting Administrator Slavitt:

Mental Health America and the undersigned individuals applaud the Centers for Medicare and Medicaid Innovation's (CMMI) incredible work in leading payment and delivery reform. The undersigned look forward to offering continuing support for CMMI in achieving its vision of transforming our nation's health care systems to truly embody the triple aim.

The undersigned also applaud the ambitious aims of this RFI. Below, we outline how CMMI could use the two strategies outlined in the RFI with the next round of State Innovation Models (SIM) funding to catalyze health care reform toward a system that promotes cross-sector alignment in supporting healthy development, and that offers the primary, secondary, and tertiary preventive behavioral interventions, translating decades of research in behavioral health treatment, prevention science, and human development to improve outcomes across a range of health conditions and offer large returns on investment for society overall. The recommendations are split into two sections, mirroring the layout of the RFI:

- **Section I:** Promote cross-sector alignment and shared accountability in addition to health care payer alignment; implement a developmental milestones framework for assessing health outcomes; and catalyze innovations in solving the wrong pocket problem.
- **Section II:** Implement family-focused interventions in pediatric primary care as a multi-state demonstration by applying existing CMMI financing models to behavioral health promotion.

Note that the recommendations in Section II represent a lighter lift for CMMI, but the recommendations are deeply complementary and would ideally be implemented together.

### **Section I Recommendation**

The undersigned offer a series of recommendations on how CMMI can use its next round of SIM funding to catalyze federal, state, and community-level collaboration to promote healthy development across the lifespan.

**Cross-Sector Alignment and Accountability.** The undersigned support CMMI in using Medicare payments to promote multi-payer alignment. In doing so, the undersigned recommend that CMMI understand payer broadly, to include other payers that impact individual health, such as social services, education including early care and Head Start, community development financial institutions, juvenile justice, and foundations.



By promoting cross-sector alignment in this fashion, CMMI would pursue one of the recommendations of the recently published series, *Vital Directions for Health and Health Care*, from the National Academy of Medicine. The authors of *Systems Strategies for Health Throughout the Life Course* state:

Harnessing society's full potential for optimizing health outcomes across the lifespan requires reaching out well beyond the health care system, from the earliest days of childhood. That potential is determined by the robustly networked interplay among systems and services that, in diverse ways, have central bearings on health prospects, and for which insights are applicable from other sectors using integrative platform models to manage the flow of goods and services.<sup>1</sup>

They propose the vital direction that health policy must “foster awareness and action on a community culture of continuous health improvement,” and explain:

Ultimately, transformative changes in health and health care require transformative leadership and action at the community level. Effective integration, application, and assessment of multi-sector and multi-domain strategies to mobilize the clinical, social service, educational, voluntary, commercial and related stakeholders—to mobilize the citizenry—on behalf better health for all, requires leadership to catalyze the emergence of the community-wide vision of the possible.<sup>2</sup>

In its next round of SIM funding, CMMI has the opportunity to take on that leadership role in organizing communities for transformative change.

At the state level, CMMI could allow non-health care payers to join the aligned payment model, with some adaptations. For example, in a system that aligns Medicare, Medicaid, and private health plans to promote accountability for health outcomes across the state, other payers (such as the state offices that administer the child care and development block grant, Head Start grants, Every Student Succeeds Act funds, for example) could have the opportunity to join and share accountability and incentives to achieve better outcomes for state.

At the community level, the Accountable Health Community (AHC) Track 3 models provide a conceptual frame for how payers could be further aligned toward totally accountable communities. The SIM offers the opportunity to align additional sectors, who may not consider themselves health-related community service providers, to mitigate population-level risks and promote health, beyond the traditional target high-need high-cost populations.

**Accountability for Healthy Life-Course Development.** In pursuing cross-sector alignment as outlined above, the undersigned recommend promoting population-level (including state-level) accountability to outcome measures of pivotal moments in healthy human development. As the Board of Children, Youth, and Families of the National Academy of Medicine noted:

Healthy human development is characterized by age-related changes in cognitive, emotional, and behavioral abilities, which are sometimes described in terms of developmental milestones or accomplishment of developmental tasks . . . Developmental competencies established in one stage of a young person's life course establish the foundation for future competencies as young people

<sup>1</sup> J. Michael McGinnis *et al.*, *Systems Strategies for Better Health Throughout the Life Course: A Vital Direction for Health and Health Care*, NATIONAL ACADEMY OF MEDICINE DISCUSSION PAPER 7 (Sep. 19, 2016).

<sup>2</sup> *Id.*

face new challenges and opportunities . . . A solid foundation of developmental competencies is essential as a young person assumes adult roles and the potential to influence the next generation of young people.<sup>3</sup>

The way in which the outcome at one stage of development affects the next is sometimes referred to as a developmental cascade. Behavioral problems in childhood can lead to decreased academic performance in adolescence, culminating in depression and anxiety in adulthood.<sup>4</sup> However, each developmental milestone provides the opportunity to halt a negative cascade and improve developmental trajectory. By measuring outcomes at each of these crucial time-points, health care systems could be held accountable for taking available opportunities to bend negative developmental trajectories.

A developmental milestone framework ranging from birth to adulthood that the undersigned recommend would include the following:

- Proportion of infants born healthy and to prepared parents
- Proportion of children ready for kindergarten
- Proportion of adolescents who use alcohol or tobacco
- Proportion of adolescents who develop mental health conditions
- Proportion of young adults ready for post-secondary life
- Proportion of adults who develop mental health or substance use conditions
- Proportion of adults who are socially included and meaningfully engaged<sup>5</sup>

Each milestone can be measured and represents both an outcome of effective preventive intervention and a robust predictor of later health conditions.<sup>6</sup> Each also represents key priorities for our nation, but for which current efforts are currently fragmented across agencies and programs. The undersigned also support the National Academy of Medicine's *Vital Signs* measurement framework and the forthcoming pediatric version, and view the developmental milestone framework as building on the "Well-being" domain across the life-course, as well as aspects of the "Preventive services" and "Addictive behavior" domains.<sup>7</sup>

Kindergarten readiness is an especially compelling milestone, given the research on the importance of the first five years of life, the research on the importance of kindergarten readiness

<sup>3</sup> Mary Ellen O'Connell, Thomas Boat, Kenneth E. Warner, and the Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults, *Preventing Mental, Emotional, and Behavioral Disorders in Children: Progress and Possibilities*, THE NATIONAL RESEARCH COUNCIL AND THE INSTITUTE OF MEDICINE (2009).

<sup>4</sup> *Id.*

<sup>5</sup> John W. Rowe *et al.*, Preparing for Better Health and Health Care for an Aging Population: A Vital Direction for Health and Health Care, NATIONAL ACADEMY OF MEDICINE DISCUSSION PAPER 5 (Sep. 19, 2016) ("[O]ne aspect of particular importance to older persons deserves attention here. A vast body of research indicates that the degree to which men and women are "connected" to others, including volunteerism and work for pay, is an important determinant of their wellbeing.")

<sup>6</sup> Mary Ellen O'Connell *et al.*, *Preventing Mental, Emotional, and Behavioral Disorders*, note 3 *supra*, at 78-80.

<sup>7</sup> David Blumenthal, Elizabeth Malphrus, J. Michael McGinnis, and the Committee on Core Metrics for Better Health at Lower Cost, *Vital Signs: Core Metrics for Health and Health Care Progress*, INSTITUTE OF MEDICINE (2015).

as a determinant of later outcomes,<sup>8</sup> and the potential to foster more meaningful integration between health care and other sectors, such as school and early care and education. For example, the recently promulgated Head Start program standards from the Office of Head Start contain an explicit focus on healthy development, as well as requirements for community and health care collaboration to foster healthy development.<sup>9</sup> The Child and Family Policy Center previously sent a letter requesting that CMMI offer a Federal Opportunity Announcement for the zero to five age range. Kindergarten readiness as a health system measure promotes health system innovation and investment in this age range, as well as supports the work of several progressive states that have already begun using the measure.<sup>10</sup>

The proposed population-level measures of the developmental cascade should be paired with more granular outcome measures that enable the provision of provider-level incentives. For example, providers could receive reward payments when they provide interventions that lead to improved scores on quantitative scales of children's cognitive, affective, and behavioral health (or the parent's well-being and preparedness to promote healthy development), which in turn would lead to better scores for the health care system at the population-level, as the individual is healthier at the next developmental milestone. Because these developmental measures are so predictive of a range of outcomes, it could also head-off the burden of measure proliferation at the provider level.

The undersigned do not take a position on which outcome measures would be most appropriate for determining provider-level incentives for promoting healthy development, but hope that CMMI could drive innovation and empirical evaluation in this area. Doing so would address the concerns that many of the undersigned shared in a previous letter to CMS on value-based payment, which is attached. The attached letter more fully outlines the issue of provider-level incentives for promoting healthy development, and how a developmental focus is currently disincentivized from a payer perspective, i.e. because of frequent health plan churn. Ultimately, the undersigned imagine a shared measurement framework not unlike NIMH's RDoC or the NIH Toolbox or PhenX being used to measure developmental competencies across the lifespan, and generate relevant incentives.

Unfortunately, because behavioral health has only been more recently mainstreamed into health care, many primary care providers would not be well equipped to benefit from the incentive regime that this measurement framework would create. Provider-level payment models may reinforce this – under the current fee-for-service framework, many of the effective interventions for promoting healthy development are not billable services, and under a capitated framework, the case rate may only allot for providers to offer currently billable services. Risk-adjustment

<sup>8</sup> See, e.g., Damon E Jones, Mark T Greenberg, and Daniel MaxCrowley, *Early Social-Emotional Functioning and Public Health: The Relationship Between Kindergarten Social Competence and Future Wellness*, 105 AM. J. PUB. HEALTH 1 (2015). See also Amie Bettencourt, Deborah Gross, and Grace Ho, *The Costly Consequences of Not Being Socially and Behaviorally Ready by Kindergarten: Associations with Grade Retention, Receipt of Academic Support Services, and Suspensions/Expulsions*, BALTIMORE EDUCATION RESEARCH CONSORTIUM (March 2016).

<sup>9</sup> *Head Start Program Performance Standard*, ADMIN. FOR CHILDREN AND FAMILIES (2016), <http://eclkc.ohs.acf.hhs.gov/hslc/hs/docs/hspss-final.pdf>.

<sup>10</sup> Carrie Hanlon and Felicia Heider, *Bridging Health Care and Early Education System Transformations to Achieve Kindergarten Readiness in Oregon*, NATIONAL ACADEMY FOR STATE HEALTH POLICY (2014).

may not reflect the amount of long-term risk an individual poses and the ability of a properly-incentivized provider to mitigate that risk. This also raises equity concerns as some children have greater risk than others and benefit from more extensive interventions, and this must be captured in the payment models. In the Section II recommendations below, the undersigned offer methods for ensuring that providers are reimbursed appropriately to transform practice and offer interventions to meet different levels of need. CMMI should also consider how the terms and length of its contracts with pediatric provider groups does or does not promote a developmental approach to health care.

**Requirements to Solve Wrong Pocket Problems.** Even with cross-sector alignment, wrong pocket problems will persist and inhibit collective action toward population-level healthy development. To the extent possible, CMMI should also use the SIM funding and CMS' role as a payer to require aligned entities to adopt policies that allow for a more equitable distribution of costs and benefits between stakeholders.

CMMI has been very effective in solving incentive misalignment issues within health care, as with accountable care organizations or bundled payment arrangements for hospital discharge. CMMI should apply those lessons learned to solve incentive misalignment across sectors. A number of innovative financing models are currently being piloted throughout the United States to address these issues, such as wellness trusts,<sup>11</sup> and CMMI could help scale some of these models, or could catalyze further innovation.

The possibilities for policies to solve wrong pocket issues are numerous. For example, could episodes be defined for cross-sector issues, such as achieving kindergarten readiness, for use in a bundled payment-type arrangement? Or could education, population and community based services, as well as health systems all share savings when effective coordination between the three reduces overall costs and improves behavioral and physical health outcomes, cognitive and educational outcomes, and overall well-being?<sup>12</sup>

There are many potential areas for innovation, and CMMI should require some attempt to solve wrong pocket problems in its SIM grants so that stakeholders have shared incentives to adequately invest in the success of the initiatives.

## **Section II Recommendation**

The Forum on Promoting Children's Cognitive, Affective, and Behavioral Health of the National Academy of Medicine recently published a landmark perspective paper, *Unleashing the Power of Prevention*,<sup>13</sup> which sought to operationalize the findings of the Board of Children, Youth, and Families since *From Neurons to Neighborhoods: The Science of Early Childhood Development*

<sup>11</sup> Jim Hester *et al.*, *Towards Sustainable Improvements in Population Health: Overview of Community Integration Structures and Emerging Innovations in Financing*, 2 CDC HEALTH POLICY SERIES (2015).

<sup>12</sup> See generally Gracelyn Cruden, Kelly Kelleher, Sheppard Kellam, and C. Hendricks Brown, *Increasing the Delivery of Preventive Health Services in Public Education*, 51 AM. J. PREV. MED. S158 (2016).

<sup>13</sup> J. David Hawkins *et al.*, *Unleashing the Power of Prevention*, NAM PERSPECTIVES (June 22, 2016).

in 2000,<sup>14</sup> to *Preventing Mental, Emotional, and Behavioral Disorders in Children: Progress and Possibilities* in 2009,<sup>15</sup> and beyond. *Unleashing the Power of Prevention* stated:

Every day across America, behavioral health problems in childhood and adolescence, from anxiety to violence, take a heavy toll on millions of lives. For decades the approach to these problems has been to treat them only after they've been identified—at a high and ongoing cost to young people, families, entire communities, and our nation. Now we have a 30-year body of research and more than 50 programs showing that behavioral health problems can be prevented. This critical mass of prevention science is converging with growing interest in prevention across health care, education, child psychiatry, child welfare, and juvenile justice. Together, we stand at the threshold of a new age of prevention.<sup>16</sup>

Out of this work, the Collaborative on Healthy Parenting in Primary Care was formed to act on one of the recommendations of this paper, which was seen as low-hanging fruit – implementing evidence-based family-focused interventions in primary care. As a recent article by many of the same authors stated:

A substantial body of research has demonstrated the positive effects of family-focused prevention programs offered in a variety of settings and across families with diverse structures and economic, cultural, and racial compositions. The positive effects of these programs indicate promise for broad public health impact on children's well-being. However, their full potential has yet to be realized because their reach has been limited. Their potential can be fulfilled by integrating them into primary healthcare settings, where most families already receive advice about child development and health. Primary care providers (e.g., pediatricians, family physicians, nurse practitioners, physicians' assistants) are often the first resource consulted when parents have concerns about their children's behavior.<sup>17</sup>

The family-focused interventions provide behavioral supports for parents and children for every level of need, from building a strong foundation before the child is even born<sup>18</sup> to helping youths with the greatest need after juvenile justice involvement.<sup>19</sup> By strengthening core cognitive, affective, and behavioral competencies for development, the interventions impact a wide-range of outcomes, including many of those that the U.S. Preventive Services Task Force seeks to prevent, such as depression, tobacco use, alcohol use, substance use, child maltreatment, intimate partner violence, risky sexual behaviors, and obesity,<sup>20</sup> in addition to offering a range of other positive societal benefits such as increased academic achievement, decreased juvenile justice involvement, decreased rates of other mental health conditions, improved child-parent

<sup>14</sup> Jack P. Shonkoff, Deborah A. Phillips, Editors, and the Committee on Integrating the Science of Early Childhood Development, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, THE NATIONAL RESEARCH COUNCIL AND THE INSTITUTE OF MEDICINE (2000).

<sup>15</sup> Mary Ellen O'Connell *et al.*, *Preventing Mental, Emotional, and Behavioral Disorders*, note 3 *supra*, at 78-80.

<sup>16</sup> Hawkins, *Unleashing the Power of Prevention*, note 13 *supra*, at 1.

<sup>17</sup> See Laurel K. Leslie *et al.*, *Primary Health Care: Potential Home for Family-Focused Preventive Interventions*, 51 AM. J. PREV. MED. S106 (2016).

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

relationships, improved relationships with prosocial peers, and promoted equity.<sup>21</sup> Economic modeling of the interventions finds that many are cost-effective, and hold the potential for reduced costs to health care in the long-term.<sup>22</sup>

However:

Although parenting programs in primary care have been shown to be efficacious and cost effective in research trials, they have rarely been sustained in primary care following the exit of the research team because these programs typically have not been covered by insurance or Medicaid. Payment problems arise around three questions. What services are billable and who is credentialed to bill for what service? Is a child diagnosis required in order to bill or are preventive parenting services for subclinical problems billable? Must the child/patient be present for preventive services provided to parents to be billable? Widespread integration of family-focused prevention programs into primary care will require addressing insurance issues through clear policy and regulatory standards so that primary care providers can be paid for these services.

The possibility of funding family-focused preventive services through primary care has been illustrated by the Healthy Steps program, the Centering Parenting program, and Triple P in Washington State, which have succeeded in arranging payment through insurance or, in the Washington State example, through state Medicaid reimbursement for Level 2 and Level 3 Triple P services provided by a pediatrician, a pediatrician's assistant, or a nurse practitioner trained and certified to deliver Triple P. These examples suggest that family-focused preventive programs in primary care can be reimbursed, but currently, family-focused preventive services are not covered consistently by private or public payers.<sup>23</sup>

Given the goals of this next round of SIM funding, CMMI has the opportunity to further break down these barriers to funding and support primary care providers in offering family-focused interventions. Multi-state implementation of family-focused interventions coordinated with primary care would build capacity for health care systems to benefit from incentives for promoting healthy development outlined in the Section I recommendations above.

Note that promoting family-focused interventions in pediatric primary care is only a first step toward transforming health care toward a developmental approach. Effective prevention and promotion will evolve with research, and an emphasis on outcomes and well-paced incentives are paramount in ensuring the rapid translation of prevention science to practice. Multi-state implementation of family-focused interventions in pediatric primary care does begin to demonstrate how larger investments in pediatric primary care lead to better health outcomes across the life-course, while increasing access to one of the most effective preventive interventions currently available.

CMMI could structure a multi-state SIM in a way that mirror existing SIMs for ease of administration. CMMI could administer a Primary Care Plus model specific to healthy

<sup>21</sup> *Id.* See also Justin Dean Smith *et al.*, *Preventing weight gain and obesity: indirect effects of the family check-up in early childhood*, 16 *PREV. SCI.* 408 (2015).

<sup>22</sup> *Benefit-Cost Results*, WASHINGTON STATE INSTITUTE FOR PUBLIC POLICY (accessed Oct. 25, 2016), <http://wsipp.wa.gov/BenefitCost>.

<sup>23</sup> *Id.*

development. In pediatric primary care, the coordination payment could go toward use of an instrument like the Well-Visit Planner,<sup>24</sup> the Safe Environment for Every Kid (SEEK) Parent Questionnaire,<sup>25</sup> or another way of engaging families to find opportunities for additional support.

The efficacy of primary care in addressing healthy cognitive, affective, and behavioral development would be limited, however, if there was no follow-up intervention available for families who sought additional supports. Family-focused interventions could be made available in areas where providers are engaged in the Primary Care Plus demonstration for healthy development, using a model similar to the Diabetes Prevention Program (DPP), i.e. a Behavioral Health Promotion Program provided through primary care. The family-focused interventions often use an approach identical to the DPP – individuals who would benefit from the additional support are convened with others in a group for multiple sessions, and they receive education and skills training demonstrated to prevent future morbidity (often using the same theory of behavior change as the DPP, although targeting different behaviors). Notably the way in which Washington Medicaid certifies certain providers for offering one of the family-focused interventions, Triple P Positive Parenting Program, is similar to the way that CDC certified organizations to provide DPP, so there is an analogous possibility of quality and cost control. Payment for the behavioral health promotion program could also be contingent on achieving certain outcomes on the provider-level developmental measures, which indicate that the intervention achieved certain levels of reductions in risk, or maintained wellness in the face of risk conditions.

Note that child care would be necessary for many families to allow them to access a Behavioral Health Promotion Program. This is the type of issue that could ideally be addressed by the kind of cross-sector alignment described in the Section I recommendations, reinforced at every step. Child care systems should share accountability with pediatrics both at the state and community-levels so that they can be most effectively incentivized for collaboration toward healthy child development.

The longitudinal data collected during the Primary Care Plus – Behavioral Health and Behavioral Health Promotion Program SIMS could go toward the creation of a risk calculator in the same fashion as the Million Hearts Cardiovascular Risk Reduction Model, i.e. a Million Minds Behavioral Health Risk Reduction Model, for key moments in development. Longitudinal analysis of the SIM sites would indicate what data collected best estimates future risk of conditions related to cognitive, affective, and behavioral development (i.e. mental health conditions, substance use conditions, injury related to child maltreatment or intimate partner violence, conditions associated with risky sexual behaviors, and conditions associated with obesity), and how subsequent interventions impact these risks. In addition to guiding clinical practice, such a risk calculator would help to justify larger case rates at earlier time points under a more flexible, capitated payment system, giving providers the ability to offer interventions that

<sup>24</sup> See Tumaini R. Coker *et al.*, *A Parent Coach Model for Well-Child Care Among Low-Income Children: A Randomized Controlled Trial*, 137 PEDIATRICS e20153013 (2016).

<sup>25</sup> Howard Dubowitz, *The Safe Environment for Every Kid Model: Promotion of Children's Health, Development, and Safety, and Prevention of Child Neglect*, 43 PEDIATRIC ANNALS e271 (2014).

maximize healthy development and giving health systems the capacity to perform well on measures of population-level development.

A risk calculator could be used to ensure that children receive evidence-based supports at key developmental phases. For example, the early years from zero to five are crucial for setting a foundation for success, as discussed above with kindergarten readiness, and pre-adolescence is an essential time-point as well. Adolescence represents a marked change in brain development for children that present new challenges to parents, as well as new risks to families. Payment structures that allow providers to mitigate risk during these developmental phases will be necessary to maximize life-course health.

### **Other Considerations**

While CMMI may be able to take steps to solve wrong pocket issues at the state and community-levels by the requirements it places on health sector grantees, CMMI is constrained by statute to address the problem at the federal level. Because CMMI is only directed to consider savings to Medicare and Medicaid in scaling up interventions, it cannot scale up interventions that are cost-saving to the federal government overall. The undersigned urge CMMI to collect data that make it possible to evaluate cross-sector savings, as advocates work to empower federal agencies to be the most effective stewards of federal spending and consider savings across the government.

CMMI can, however, incentivize innovation. Given CMS' role in funding graduate medical education (GME), CMMI can potentially also work to ensure the future workforce are ready to foster child development in primary care. In partnership with other sections within CMS, CMMI should consider ways of incentivizing children's hospitals and academic medical centers to include trainees in their innovations to build capacity in the future workforce.

### **Conclusion**

The undersigned appreciate CMMI's consideration of how the next round of SIM funding could most effectively promote healthy life-course development. Please reach out at any time to Nathaniel Counts, J.D., Director of Policy at Mental Health America at [ncounts@mentalhealthamerica.net](mailto:ncounts@mentalhealthamerica.net).

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**SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

	<b>Response</b>
1. What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?	<p>The level of interest is dependent on the level of flexibility the State is provided with, as well as, the level alignment with existing value based purchasing/alternative payment arrangements investments that have already been made in the State.</p>
a. What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?	<p>Maine's Medicaid program has been instrumental in moving the needle to APM's through the health homes, behavioral health homes and accountable communities models. States face several challenges in achieving all-payer alignment of new payment models. We identify some of the most significant of these to include:</p> <ul style="list-style-type: none"> <li>• Ability to operationalize new payment models, particularly if/as those models require infrastructure, technology, and/or other investments that payers may not have the resources to commit</li> <li>• Ability to get agreement on specifics of new payment models, particularly from national payers that have varying business needs in different states</li> <li>• Ability to track meaningful outcomes, particularly patient-centered outcomes</li> <li>• Ability to create models that are not overly complex and can be implemented by small provider groups</li> </ul> <p>In order to leverage the collective influence of the commercial sector, a concerted effort must be undertaken to organize commercial purchasers around CMS' pay-for-value proposition, support alignment of their payment structures with CMS models, and communicate a consistent approach to providers regarding how the commercial market intends to pay for value, not volume, in health care. The SIM Governance structure of the SIM Steering Committee and the Medicare Proposal Oversight Committee has succeeded in payer involvement and investment. SIM will continue this work in the next year.</p> <p>Broad-based alignment among commercial purchasers around alternative payment models also will motivate commercial payers to participate. As Maine's response to the CPC+ initiative showed, payers will not necessarily opt to participate in alternative payment initiatives on their own. Clear and</p>

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	from SIM stakeholders collectively will create strong incentives for commercial payers to support the new payment models that their customers are demanding.
<p>b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?</p>	<p>Successfully advancing a value-based payment model requires alignment across commercial and public payers so that providers have sufficient incentives and support to transform care delivery. As CMS noted when launching the Health Care Payment Learning and Action Network to promote multi-payer value-based payment efforts, “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 the largest purchasers of healthcare services, commercial purchasers are essential to any successful effort to reform healthcare payment.</p> <p>There are two key components to achieving broad payer alignment that engages commercial purchasers and leverages their market power to advance change. First, commercial purchasers must be organized around the same value proposition that CMS has created for Medicare.</p> <p>Second, commercial purchasers must be involved, from the outset, in development of any multi-payer value-based payment initiative. The Medicare Proposal Oversight Committee has achieved involvement from payers.</p> <p>Robust all-payer data also is essential to multi-payer reform efforts—both to support improvement and to ensure accountability. Specifically, claims data are needed to measure the cost impact of alternative payment models across payers and against spending targets. With cost shifting a long-standing feature of the healthcare system, it is critical that the total cost of care be measured across all payers—Medicare, Medicaid, and commercial—to ensure that lower costs for one payer (such as Medicare) are not simply the result of shifting costs to another payer.</p> <p>Claims-based analytics are also critical tools to help providers understand cost, utilization, and quality trends for their attributed populations compared to state benchmarks, and to identify variation and actionable opportunities for improvement. Commercial and public payers will also need this information to evaluate and compare performance in alternative payment arrangements and to undertake data-focused improvements that identify and support providers around priority measures, such as diabetes. MHC is currently using these data to adjudicate both commercial ACO contracts and MaineCare accountability communities contracts.</p>

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	<p>While strong alignment with Medicare payment models is critical, program design must allow individual payers flexibility to incentivize their specific priorities and also give providers the ability to choose from a range of value-based payment methods (i.e., tiers) that are tailored to match different levels of provider readiness. Adherence to the HCPLAN Alternative Payment Model (APM) framework provides adequate guidance to achieve the balance between consistency and flexibility.</p>
<p>c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?</p>	<p>The primary challenge facing state Medicaid programs is the lack of flexibility within the existing state plan amendment process. This lack of flexibility and state control causes an inability to make timely and innovative changes. While we understand that a waiver is one potential tool for gaining flexibility, the administrative resource and time that goes into gaining and maintaining approval makes that tool ineffective.</p> <p>Secondly, the lack of communication between the regional and central CMS offices and CMMI poses significant challenges. CMMI continues to attempt to bring innovation and flexibility into the system, however, the party responsible for approving such changes, CMS, does not share the same general principles; nor does the archaic state plan amendment process.</p> <p>Another challenge is timeliness of data. Because of federal timely filing requirements, we face challenges of basing payments off of data that is 1 year + old.</p> <p>The state would need flexibility to waive certain requirements and the ability to manage said programs under an authority that allows for timely changes and flexibility to make changes as the State sees fit.</p>
<p>d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program</p>	<p>As noted above, alignment across commercial and public payers will be important to achieve transformation of health care delivery. In order to leverage their considerable market power to advance value-based payments, commercial payers must be proactively organized. Efforts to align across commercial and public payers must utilize a balanced governance structure with commercial purchasers as participants. Resources would be needed to continue the Medicare Proposal Oversight Committee (MPOC) and to educate and engage payers in the reform effort, and to facilitate and support the MPOC multi-stakeholder meetings that solicit all-payer input on key components of the model, including those discussed above.</p> <p>Resources must also be available to support access and analytics around clinical and all-payer data. Such data are essential to measuring the cost impact of alternative models over time and</p>

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integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?	<p>across payers; allowing payers and health systems to evaluate performance on risk-based contracts; and helping providers to understand cost and utilization patterns compared to state benchmarks and identify opportunities for improvement. Resources would be needed to access, process, and analyze clinical and claims data on an ongoing basis. Specifically, in order to generate analytically functional clinical and claims data that support the analyses described above, resources must be available to perform data validation, mitigate data limitations where possible, and apply value-added analytics—such as risk adjustment and episode groups.</p> <p>A comprehensive and up-to-date provider database is essential to any efforts to integrate and attribute performance measures to a particular provider, practice, practice group, or system. Resources are needed for ongoing updates and maintenance to keep the database current.</p> <p>Technical assistance will be critical in helping providers (particularly smaller group practices) understand risk-adjusted cost, utilization, and quality data so that they can identify opportunities for improvement (particularly vis a vis metrics included in a common measure set or a particular contract), and undertake strategies to improve performance. Resources would be needed to support such data and practice transformation training.</p> <p>Following the Supreme Court decision on <i>Gobeille</i>, it is unclear whether comprehensive commercial data will be available through state all-payer claims databases. Policy or regulatory changes at the federal level that institute data reporting requirements on ERISA-covered plans could assist in this regard.</p> <p>Improving Health Outcomes on a Statewide Basis: Improvements in health outcomes will require more coordination between community based organizations and the healthcare delivery system. Payer contracts could have provisions that supported sustainable structures across health systems and their surrounding communities to sustain and deliver evidence-based chronic disease prevention, control, and self-management programming. If the health system is required and empowered in their payer contracts to pay community based organizations (CBO) to scale and deploy evidence-based programs and self-management support structures, the CBO would be complementary to the health system's expertise. The basic premise is "people taking care of themselves, within their communities". Incentivize by paying a higher PMPM for</p>



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	<p>populations who are staying well or have moved outside of risk for diseases/complications; i.e. pay more for people to stay well.</p> <ol style="list-style-type: none"> <li>I. Funding: Have more of the resources/spend in the contract designed to be used in population health management. Use monies in the payer contract for population health management and require that it is used for engagement with community-based organizations and partners near or within the social networks of those in the target population. This will facilitate the evidence-based programming and self-management support structures needed for the target population(s).</li> <li>II. Infrastructure Support: These funds should not be limited in any way except that they cannot be used for current programs currently being paid for under other APMs (ACO, Care Management, CCT etc.).</li> <li>III. Technical Assistance: Social Network Analysis with target populations should be part of TA; this will assist health systems and their CBO partners to identify the highest value social networks to foster in their population health management plan. Support on how to build/design/write contracts with CBOs to ensure that provisions are being used for facilitating/tracking target the populations and their health outcomes is also of value.</li> <li>IV. Policy Changes: Pay and incentivize health systems to partner/contract with CBOs to spend monies on evidence-based programs and interventions that reach target populations with these programs. Pay incentives to those health systems that perform well (ex. Greater than 40% of target population "Diabetes" have enrolled and completed Diabetes Self-Management Training (DSMT) and are actively participating in Diabetes Self-Management Support (DSMS) as it is defined in "X" Community; those whose health outcomes have indicated a measured improvement in A1c control in the previous 12 months - NQF 0575) get paid more for health outcomes/performance improvements every 6-12 months. Low performers get less spend if they are not facilitating improvements in population health status for target population after 24 months from baseline.</li> </ol> <p>Rural Community Health Disparities</p> <p>Rural communities face several challenges in implementing new payment models, including a provider network that is often made up of small provider groups with limited administrative support and resources; small patient panels; and often higher levels of Medicare &amp; Medicaid populations. To help address those issues, CMS could consider several approaches:</p>

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	<ul style="list-style-type: none"> <li>• Implement new payment and delivery system model that support and encourage the creation of “virtual groups” of providers across a region (that may not be otherwise affiliated), such as proposed in the QPP. These virtual groups could provide a basis for pooling patients for the purpose of assessing risk severity; measuring clinical and financial performance of provider groups, avoiding the “small numbers” problems often faced by small and rural providers</li> <li>• Provide support and incentives for regional/pooled resources such as community-based care management teams (such as Maine’s Community Care Teams or Vermont’s Community Health Teams) that provide shared resources across several small/rural practices</li> <li>• Provide direct, on the ground technical assistance to these providers, similar to the agricultural extension service model</li> <li>• Consider including an adjustment for rural practices and patients when calculating patient risk severity adjustment scores, recognizing the additional burdens faced by patients in rural areas (e.g. transportation, lack of resources)</li> </ul> <p>Operationalize Reforms:</p> <p>Maine remains excited about the capabilities that SIM has provided to test innovations across healthcare transformation spectrum. We believe that the SIM program is in a good place to continue through greater concentration in areas that have proved promising and successful based on data and experience. While the operationalizing these results will be challenging, we understand that this is the true nature of innovation. Try, learn, and adjust. We believe that the SIM governance structure will provide an effective environment for active healthcare transformation, and set the stage for the development of sound sustainability strategies that will continue to involve input and engagement from all of the stakeholders of healthcare transformation. In order to continue Maine’s healthcare transformation the support of CMMI is needed.</p> <p>The current SIM work has yielded the following results. We hope to be able to continue to support our multifaceted transformation efforts in the future.</p> <ul style="list-style-type: none"> <li>• Non-emergent ED use showed a 14.0% decrease in the MaineCare Stage A Health Home group compared to a 2.6% decrease in the comparison group. The goal is to see a decrease in non-emergent ED use.</li> <li>• MaineCare Stage A Health Homes generated notable cost avoidance of \$110 per member per month (PMPM) over a matched control group.</li> </ul>

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	<ul style="list-style-type: none"> <li>• A 22.6% increase in facility outpatient clinic costs for the intervention group, compared to a 52.2% increase for the control group. Members in MaineCare Stage A Health Homes were more likely to get the services they need at their primary care office.</li> <li>• A 14.0% decrease in non-emergent Emergency Department visits in the intervention group, compared to a 2.6% decrease among the control group. Decreased reliance on Emergency Departments for non-emergent care likely reflects a strengthening of primary care and coordination that is helping to keep MaineCare Stage A members out of higher cost, institution-based service areas.</li> </ul> <p>The evaluation findings thus far are promising and will continue to be studied for the duration of the SIM grant, and these data driven findings will serve as a guide for DHHS investment adjustments.</p> <p>SIM has identified key success areas for sustainability focus beyond the current SIM award:</p> <ul style="list-style-type: none"> <li>• The development and refinement of healthcare models that have specific focus on improvement of quality and cost and are designed to share the risk in obtaining said results between providers and payers</li> <li>• Technologies that improve communications between providers, payers, case managers, and other parties that partner in patient care</li> <li>• Technologies that improve communication between physical and behavioral healthcare providers</li> <li>• Technologies that improve patients' ability to effectively engage with their providers and manage their own health</li> <li>• Targeted focus on the provision of transparent data on cost and quality</li> <li>• Increasing public reporting of behavioral health cost and quality data</li> <li>• The development of informational tools that align healthcare cost and quality measures across organizations and payer populations</li> <li>• Technical assistance to support providers, both physical and behavioral health, that focus on quality improvement and cost reduction <b>outcomes</b>. This technical assistance model should be coordinated and collaborative among all payers, providers.</li> </ul>

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	Response
	<ul style="list-style-type: none"> <li>Extension and expansion of the National Diabetes Prevention Program</li> </ul>
e. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?	Innovation takes time! At the LAN conference Governor Leavitt spoke to the fact that we are early in the innovation curve. Support from CMS beyond three years is necessary in order for innovation to be operationalized, transformative and sustained.
f. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?	Recognizing that models will be different in different states, CMS could support comparable cross-state evaluation efforts by focusing on identifying standard outcomes measures for all programs, using a mix of clinical, cost, and patient experience measures, including patient-reported outcomes.
g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?	<p>Given the complexity and range of changes occurring concurrently in most states and areas of the country, CMS may consider its approach of evaluating one model at a time, and perhaps use a mix-methods model of evaluating changes in each state, allowing multiple models to co-exist, but including a description of the multitude of efforts going on in any given state. The evaluation could focus more on describing what factors do not appear to most significantly contribute to success in improving outcomes, rather than trying to “purely” isolate specific programs or changes, as this is virtually impossible given the number of changes going on in each region.</p> <p>Rural states like Maine could pilot alternative payment models that are tailored to address the specific circumstances and concerns of smaller providers—a group currently exempt from many MACRA requirements—and support rural practices with risk-adjusted cost and utilization data, measurement analyses, and technical assistance. CMS could use those results to more fully and equitably integrate smaller providers into Medicare payment models such as MACRA. CMS could also look to state pilot innovative ways to coordinate the choices that MACRA affords providers around quality measures, such as a statewide, multi-stakeholder QCDR to develop a meaningful, outcomes-based common set of metrics that can be used for MACRA and by commercial payers.</p>
2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the	

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population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.

a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.

Utilize current and most common measures for health care/outcomes performance improvement (example: NQF measures). Allow CBOs to utilize current evidence-based program tracking tools to monitor and report the performance/outcomes for participants. Please do not require new reporting that will cost large spend on behalf of CBO's. If social service agencies are able to track the number of social service program connections/referrals and utilizers every 6-12 months, this will demonstrate improvements in the social network and this will lead to health outcomes/performance improvements.

Through SIM, a common measure set adopted through a multi-stakeholder SIM-supported process has achieved broad adoption, with systems and health plans reporting that between 66–72% of 2015 ACO performance measures were from the core set. The measure set includes outcomes-based metrics around diabetes, hypertension, and readmissions measures.

b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?

A major focus of Maine's SIM award was development of robust data resources to help stakeholders evaluate and improve performance. One key data source available to payers and providers is claims-based data. Payers and purchasers use claims data to compare provider performance against state benchmarks and to measure performance on cost and quality metrics within risk-based contracts.

There are some limitations to claims data, mainly the time lag around its availability (due largely to run-out). Nor do claims data include payment methods outside of the claims process, such as shared savings, care management, etc.). As such alternative payment arrangements increase, strategies for capturing those payments must be pursued to capture this additional information.

Combination of clinical and claims data would be of great value to all providers.

c. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific

A specific challenge is assuring that health benefits follow persons with chronic diseases through

**SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

	<b>Response</b>
challenges that need to be overcome to offer population-level services across state lines?	prevention and treatment. To take diabetes as an example – it is important for payers to pay for continuous glucose monitoring to assist with persons being able to control their diabetes. Another current challenge is the lack of coordination between clinical health care and community based chronic disease self-management support. In order to assist with these critical linkages we would encourage consideration of a requirement for clinical care providers to earmark funds for collaboration with community based chronic disease self-management support. Another challenge when continuing with the diabetes example is to assure that referrals to endocrinologists are covered as for many diabetics this level of care is an essential service. CMS may consider paying for and requiring that population health monitoring is part of community planning and allow health care organizations the ability to spend a portion of their contract provisions to support public health and social health support for communities willing to put forward population health management plans with measureable goals and outcomes. CMS could consider funding these start-up efforts, and continue to fund these efforts much like a Wellness Trust if these communities and their population health management plans yield measureable population health improvement results within 4 years.
3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.	
a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?	The State of Maine's Maine Health Data Organization (MHDO) is required by State law to maintain a comprehensive healthcare data base which currently consists of claims data from all three payer categories: Commercial, the State's Medicaid program-MaineCare and Medicare. In addition, the MHDO collects all hospital inpatient and outpatient encounters (including provider based clinics), hospital quality data, hospital financial and organizational data. The MHDO is required by State law to promote the transparency of health care costs and quality information at the procedure level for the top players in the State. In addition, the MHDO is required to release the data in accordance with 90-590 C.M.R.

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	<b>Response</b>
	<p>Rule Chapter 120, Release of Data to the Public, to entities that will use the data to improve the cost and quality of healthcare in the State. The MHDO has been collecting multi-payer claims data for over 10 years. The data the MHDO collects can provide the benchmarks and monitoring of trends for Medicare, Medicaid, and Commercial populations.</p> <p>Merging clinical and claims data forms the basis of the predictive analytics tested in SIM years 1-3 for the Medicaid (MaineCare) Program. In year 4, these analytics are being deployed to 3 medical practices that are members of the Accountable Communities Initiative and/or Health Home initiative. The purpose of this pilot deployment is to:</p> <ol style="list-style-type: none"> <li>1. Demonstrate that predictive analytics can be deployed successfully in a care management workflow in use by nurse case managers, RN's, and medical assistants.</li> <li>2. Measure the impact of the use of these predictive analytics on: <ol style="list-style-type: none"> <li>a. 30-day all-episode readmissions</li> <li>b. Inappropriate 30-day readmissions as defined by CMS</li> <li>c. Emergency Department (ED) Utilization (monthly)</li> <li>d. Non-emergent ED utilization as defined by MaineCare and SIM</li> <li>e. Inpatient Admissions</li> </ol> </li> </ol> <p>The analytic tools being tested under the SIM Grant only merge clinical and claims data for Medicaid patients/members.</p> <p>As a statewide deployment, payer claims data will be needed from Medicare and Commercial payers in order to effectuate change and adoption across the broader provider community. Maine would benefit from a fully identified – all-payer claims data (Note: Although the State of Maine has an All-Payer Claims Database (APCD), managed by the Maine Health Data Consortium (MHDO), the enabling legislation for the APCD, requires de-identification of the data. In addition, the recent Supreme Court decision (Gobeille v. Liberty Mutual LLC), is likely to render significant gaps in the APCD database due to the non-inclusion of ERISA Plan data. Specific resources need to be requested for the following:</p>

**SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

	<b>Response</b>
	<ol style="list-style-type: none"> <li>1. A comprehensive request for identified Medicare Claims data to be submitted to the statewide Health Information Exchange (HIE) as a flat file secure EFT transfer to HealthInfoNet. Specific staging databases need to be created to securely encrypt, store and replication of this data into the HIN merged clinical-claims database. This includes building new enterprise-level patient (person) identifiers in the HealthInfoNet enterprise master person index (EMPI).</li> <li>2. Resources are needed to convene executives from the Commercial Payers to negotiate a direct feed of claims data to the statewide HIE. The statewide HIE, as a neutral party not involved in delivery or payment of healthcare represents the ideal convener of these discussions and negotiations. This process should be given a short time-line with clear incentives developed for the commercial payers to participate. Specific goals need to be set to: <ol style="list-style-type: none"> <li>a. Identify a value proposition for the commercial payers to participate and “share” claims data. Discussion could include the following: <ol style="list-style-type: none"> <li>i. Data ownership, provenance, access, authorization and security.</li> <li>ii. Patient consent</li> <li>iii. Business “rules” for privacy for all</li> <li>iv. Role-based access</li> </ol> </li> <li>b. Clearly articulate a timeline for agreement and project operationalization.</li> <li>c. Develop and agree to a Memorandum of Understanding (MOU) that outlines the “rules of the road” for payer participation in the HIE and Statewide Analytics.</li> </ol> </li> </ol> <p>We are considering developing a solution utilizing the statewide HIE that can be leveraged as a means to populate the APCD structure to allow for reduced operational burden of managing consent, data security, patient identifiers, and linkage of claims and clinical data).</p>



**SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS**

	Response
<p>b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and healthcare data; appropriate measures)?</p>	<p>The MHDO claims data is available for use on a timely basis. Both MaineCare and the Commercial payers submit data to the MHDO on a monthly basis. The MHDO generally makes that data available to users of the data 90 days after the close of each quarter. The MHDO now receives Medicare data on a quarterly basis as well, with a slightly longer lag.</p> <p>The MHDO collects provider level data. The current submission layout allows for the gathering of rendering, billing, attending, and operating providers, as well as service facility on the claim record. However, one major gap is the lack of a standard mechanism to assign providers to group practices. Additionally, while the use of the NPI to identify providers is quite good with over 95% of claims having at least one NPI provided. However, the NPI provided may not always be that of the actual provider directly performing the service and may instead represent a group or individual who is billing the service. We are continuing to work with our data submitters and users to better understand these issues and develop strategies to address them.</p> <p>To date, the linking of the MHDO claims data to other data sources has been done in very limited ways. There are examples of the linking of APCD data with Cancer Registry data, for example, in Maine and New Hampshire. There is also a great interest and some limited examples of linking APCD data to clinical data in Health Information Exchanges (e.g., in Vermont). Tying APCD data to other data sources remains an area of great interest at the state level. Over the last several years the MHDO has been refining its infrastructure and processes in order to prepare for the new needs of the data users which includes for example associating payment to outcomes and the integration of claims data with other data streams.</p> <p>Due to its role as the statewide HIE, HealthInfoNet is serving as the statewide aggregator of clinical data across EHRs, laboratories and pharmacies. Due to the statewide EMPI that is managed by HIN, under a RWJF grant HIN began collecting social service data in 2016. This work has expanded to include a new "Social Service" portal being managed and operated</p>

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	by HIN to support coordination between the provider community, social services agencies and the government. It is anticipated that this work will continue and under SIM year 4, a new access point for this data is being deployed for the ME Centers for Disease Control to allow role-based access to clinical, claims, and social services data that can be measured.
c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?	MHMC has used Medicaid claims data to develop extensive ACO and practice level analyses outlining risk-adjusted variations in quality of care, cost, and utilization. Working with the state Medicaid program, MHMC has created reports for all Maine primary care practices detailing performance on their attributed Medicaid population over time, benchmarked against peer and statewide averages. MHMC also uses Medicaid claims data to assess performance on cost and quality metrics by Medicaid Accountable Communities.
d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?	The MHDO has the capacity to perform data analysis through a partnership with our data management contractor. Data analysis comes at a cost especially given the complexity of the work. As stated above we have the expertise through our contractor. The MHDO would need to assess the resources needed in the work of analyzing outcomes measurement.
g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?	<p>The MHDO continuously monitors payer compliance to ensure that mandated data submitters provide claims and hospital encounter information that meets the requirements of the law. Incoming data quality and integrity checks are an important aspect of the Maine Health Data Organization's data intake process. In fact, we have created over 500 front end validations that the claims and hospital data process through before we will accept the data into our system. The overall quality of each data release is assessed on a quarterly basis before each data release.</p> <p>The MHDO does not currently collect any data specific to particular programs but could do so through a rule making process.</p>

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	<b>Response</b>
<p>h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?</p>	<p>In Maine we have the HIE, MHDO and the MHMC which have contributed to the IT infrastructure which are all part of SIM. Resources described above will further enhance the HIE's ability to combine clinical and claims data for extract, transport, transform, aggregate, analyze and disseminate all health and wellness data collected.</p> <p>SIM resources expanded and enhanced the MHMC work to develop the infrastructure and expertise within an analytically functional claims data warehouses to (1) create claims-based, risk-adjusted practice reports that give providers a rich set of data regarding their performance against state benchmarks on cost, utilization, and quality measures across all payers (Medicaid, Medicare, and commercial), and (2) measure cost and quality performance of accountable care arrangements for both Medicaid and commercial payers.</p> <p>Additional resources will be needed to support continued access to and analysis of all-payer claims data, but the infrastructure and expertise already in place in Maine represent a strong foundation that can be leveraged moving forward.</p>

**SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES**

<p>1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically, we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).</p>	<p>This work has already begun in the State of Maine, specifically through our Health Homes, Behavioral Health Homes and Accountable Care programs. For example, we have recently instituted a data focused learning collaborative approach for our HH &amp; BHH providers, providing targeted technical assistance to improve work flow and outcomes in regards to diabetic and pre-diabetic care.</p> <p>The State would be much more amenable to being used as a platform, if the test was based on programs/initiatives that are already in place.</p> <p>Otherwise, the State would need state plan requirements regarding freedom of choice of provider and state wide access in order to implement any kind of pilot.</p>
<p>2. Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where</p>	<p>More information would be necessary, before we would consider participation.</p>

SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES	
appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?	
3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.	Maine has shown significant findings related to Health Home and Behavioral Health Homes. Further analysis is warranted.
4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality healthcare and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.	<p>In advancing new delivery system and payment models, CMS could help to address disparities for vulnerable populations through several strategies:</p> <ul style="list-style-type: none"> <li>• Support the development of systems for our statewide HIE (and related incentives) for providers to capture and track social health factors that contribute to disparities (e.g. housing, lack of transportation, food security)</li> <li>• Include these social health factors in calculations of risk adjustment models</li> <li>• Encourage the public reporting of outcomes by provider group using stratification by payer type as a proxy for social health burden</li> <li>• Remove barriers to using Medicare and Medicaid funding to address social health needs (e.g. housing)</li> </ul>
SECTION III: STREAMLINED FEDERAL/STATE INTERACTION	
1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?	<p>The State of Maine has utilized CMS TA, at times, to connect with other states.</p> <p>Increasing efforts around making state to state/regional connections.</p>
2. How can CMS/HHS better align in order to support state delivery system reform efforts?	<p>Increase coordination between CMMI and CMS (the authority responsible for approving the state plan amendments and waivers necessary to implement any alternative payment model or delivery system reform)</p> <p>Create a streamlined SPA/waiver process for initiatives that support innovation around delivery system and/or payment reform.</p>

October 28, 2016

Patrick Conway  
Deputy Administrator for Innovation & Quality,  
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Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, M.D. 21244

***VIA ELECTRONIC DELIVERY***

**RE: Request for Information on State Innovation Model Concepts**

Dear Deputy Administrator Conway:

The Biotechnology Innovation Organization (BIO) is pleased to submit the following comments regarding the Request for Information (RFI) on State Innovation Model (SIM) Concepts, released by the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI).<sup>1</sup>

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or to prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions.

BIO represents an industry that is devoted to discovering new treatments and ensuring patient access to them. Accordingly, we closely monitor changes to Medicare's reimbursement rates and payment policies for their potential impact on innovation and patient access to drugs and biologics. BIO applauds CMMI's interest in obtaining broad stakeholder input through the RFI process on the issue of SIM concepts. We support the Agency's broader goals to improve quality of care and reduce overall Medicare expenditures, and believe appropriate access to, and utilization of, medicines can contribute to both goals. Innovative therapies have the potential to dramatically improve patient health in the short- and long- term, and in so doing, decrease spending on other healthcare services (e.g., hospitalizations)—outcomes which should be considered in the calculation of a demonstration's impact. Thus, a prominent theme throughout BIO's feedback on the RFI is that any demonstration(s) that stems from this activity should not only maintain, but improve, patient access to needed therapies.

In particular, in considering the potential application of this type of model, we encourage CMMI to ensure that patient access to needed therapies is not delayed, providers are not unduly penalized for the underlying health of their patients, and that longer-term incentives for sustaining the biopharmaceutical ecosystem are sustained. Each of these issues is discussed in more detail in the balance of this letter.

<sup>1</sup> Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation, 2016, Request for Information on State Innovation model Concepts, available at: <https://innovation.cms.gov/Files/x/sim-rfi.pdf> (last accessed on October 10, 2016)

- I. **Section 1(d): What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center Models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reform?**

#### **A. Accountability Mechanism for Total Cost of Care**

In this section of the RFI, CMMI requests information on potential accountability mechanisms in place at the state level to comply with total cost of care limits established under a SIM. BIO notes that not only are such mechanisms critical to the success of a SIM, but that these mechanisms must be complemented by robust quality measures that can serve as a bulwark against a sole focus on cutting costs. Thus, BIO urges CMMI to work with individual states to ensure that maintaining or decreasing total costs of care under a SIM is balanced with maintaining or improving the quality of care patients receive.

As an initial matter, BIO notes that ensuring that a state has mechanisms in place to be accountable for SIM-set total cost of care metrics will depend on whether the state has the data infrastructure to collect this information from participating providers, and the extent to which the participating providers are able to report such metrics in a timely, standardized manner. CMMI should examine whether a state has this threshold capability as part of the initial process of assessing whether a SIM is feasible.

In the consideration of establishing total cost of care metrics under a SIM, CMMI should aim to ensure that budgets set under any potential demonstration are predictable and the methodology clearly communicated to participants. This will help to ensure that any expenditure goals set are feasible from the point of view of participants, including states and all participating payers. Additionally, CMMI should consider establishing state-specific targets for Medicare savings and limits on the growth of spending by other payers, to account for the local environment(s) within a state, and ensure that such targets are realistic based on historical spending. Enforcing targets that require too significant a decrease in total costs of care, especially in the first year of a SIM, can incentivize care rationing and underutilization of appropriate care, both of which can lead to poorer health outcomes for patients and increases in overall healthcare spending (e.g., resulting from an increase in emergency department visits).

Though BIO recommends that CMMI and states set total costs of care targets that are realistic in the context of historical spending, we caution that there are concerns with establishing targets based on historical spending alone. For example, targets based on historical costs alone are inherently unable to take into account the evolving standard of care. This is of particular concern for patients who utilize innovative technologies—including biopharmaceuticals—as part of their overall treatment regimen. Specifically, BIO is concerned that, unless state targets for total costs of care incorporate a mechanism to account for new technologies that come to market during the middle of a SIM implementation year, patient access to these technologies may be delayed, to the detriment

of patient health outcomes and potentially overall expenditures (e.g., in the event that the new technology replaces the need for additional hospitalizations, surgical interventions, and physician office visits).

One mechanism CMMI should consider helping states to implement in the context of a SIM to account for new technologies in overall budget targets is to carve out payment for novel technologies for the first year (or several years) that the product is on the market.<sup>2</sup> This type of mechanism would ensure that providers are not disadvantaged if they decide, based on the clinical circumstances of an individual patient, to prescribe the new product. It also would allow the state time to collect and analyze information about the benefits, costs, and cost-offsets of the new technology before taking it into account in the context of the target total costs of care and the limits on growth in spending by other payers. No matter how CMMI and states account for new technologies in the context of SIMs, the process for doing so must be transparent and predictable.

## **B. Measurement of Health Outcomes on a Statewide-basis**

In this section of the RFI, CMMI asks stakeholders for feedback on how to improve health outcomes on a statewide basis under a SIM. In response, BIO notes our support for statewide measurement of health outcomes, with the underlying goal of creating efficiencies in collecting and analyzing data on quality and effectiveness of care across a large population (potentially across an entire state). However, we note that the ability of a global and/or population-based measure to accurately reflect the care an individual is receiving under a SIM will vary significantly depending on the type of care, the expected homogeneity of the impact of that care on a patient population, and the condition/disease the care is meant to prevent, diagnose, and/or treat. While this may be more appropriate for certain aspects of primary care (e.g., the provision of vaccines), using global measures to assess the care that patients with complex, chronic conditions are receiving may obscure important nuances in care delivery and its impact on patient health outcomes. Thus, we caution CMMI and states against relying solely on statewide measures of health outcomes unless there is evidence to suggest that such measures can appropriately capture the quality and effectiveness of care that individual Medicare beneficiaries receive. Instead, SIMs should provide for the measurement of quality of care and patient health outcomes specific to the characteristics of a patient population.

Additionally, BIO strongly encourages CMMI to require states participating in SIMs to establish mechanisms to collect provider and patient experience data. While potentially resource-intensive, this source of information is critical since quality-of-care measures may not be specific enough to identify issues that arise only for certain provider and/or patient subpopulations or under certain private payers. BIO also recommends that CMMI require states to analyze data collected more frequently than just annually, as patient access issues that arise unexpectedly could have serious and acute implications. CMMI also should consider requiring states to make this data evaluation public (in the aggregate and de-identified) at specific intervals to allow stakeholders an opportunity to perform independent analyses and allow the data to be utilized to refine the SIM.

<sup>2</sup> Note: Carving out payment for new technologies is a mechanism already utilized in Medicare under the Outpatient Prospective Payment System transition pass-through payment process.

### C. Program Integrity

In this section of the RFI, CMMI asks stakeholders for input with regard to how the Agency can assist states participating in SIMs to develop mechanisms to maintain, and/or improve, program integrity. With respect to the Medicare program in particular, BIO urges CMMI and states to closely monitor continued compliance with patient access requirements under Medicare, and all appeals and exceptions processes. CMMI should identify whether states interested in participating in SIMs have the data infrastructure to monitor all aspects of program integrity, as a threshold for engaging the state in such a model.

Since the aim of SIMs is to involve all state payers, BIO notes that there are key program integrity elements related to nondiscrimination that SIMs should take into account as well. We use the opportunity of the RFI question to reiterate our concerns with the lack of sufficient federal and state oversight of compliance with existing requirements that prohibit health insurers subject to Essential Health Benefits under the Affordable Care Act from discriminating against individuals on the basis of personal characteristics, including demographics and health status.<sup>3</sup> Given CMMI's interest in including all payers in SIMs, ensuring compliance with existing nondiscrimination standards is a key element of program integrity for which SIMs should account. In fact, the development and implementation of SIMs should be considered a prime opportunity to pilot more robust oversight and enforcement mechanisms to ensure compliance with nondiscrimination requirements. CMMI has an important role to assist states with this. For example, the Agency could work within CMS to aggregate, and provide to states considering participating in SIMs, best practices related to needed oversight and enforcement activities. A detailed discussion of the need for, and potential mechanisms to address gaps in, oversight and enforcement of nondiscrimination standards is included in BIO's comments in response to CMS's *Nondiscrimination Proposed Rule*, released in 2015, and herein included by reference.<sup>4</sup>

Similarly, to the extent that SIMs will incorporate Medicaid beneficiaries, we strongly urge CMMI to work with states and the Health Resources and Services Administration (HRSA) to ensure program integrity related to the statutory prohibitions against diversion<sup>5</sup> and duplicate discounts<sup>6</sup> in the 340B program.<sup>7</sup> Over the last 10 years, the Government Accountability Organization (GAO) and the Department of Health and Human Services Office of Inspector General (HHS-OIG) have consistently called for improved program integrity within the 340B program.<sup>8</sup> In fact, the audits of covered entities participating in the 340B program, conducted by HRSA, have revealed high rates of non-compliance with program

<sup>3</sup> ACA § 1201 (codified at section 2705 of the Public Health Service Act) (prohibiting "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage [from] establish[ing] rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual: (1) Health status; (2) Medical condition (including both physical and mental illnesses); (3) Claims experience; (4) Receipt of health care; (5) Medical history; (6) Genetic information; (7) Evidence of insurability (including conditions arising out of acts of domestic violence); (8) Disability; (9) Any other health status-related factor determined appropriate by the Secretary," and that "[n]othing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations in connection with this section.")

<sup>4</sup> BIO, 2015 (November 9), *Comments in Response to the Department of Health and Human Services Nondiscrimination in Health Programs and Activities Proposed Rule*, RIN 0945-AA02, available at: <https://www.regulations.gov/document?D=HHS-OCR-2015-0006-0001> (last accessed October 17, 2016).

<sup>5</sup> Defined as furnishing a product purchased through the 340B program to a non-340B "patient."

<sup>6</sup> Defined as the state seeking a Medicaid rebate on a product purchased through the 340B program.

<sup>7</sup> Public Health Service Act (PHSA) § 340B(a)(5)(A).

<sup>8</sup> GAO. 2011. *Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement*, Report 11-836, Available at: <http://www.gao.gov/assets/330/323702.pdf>.



requirements.<sup>9</sup> Thus, BIO continues to urge CMS and HRSA to coordinate with each other and with states to improve program integrity in the 340B program. Moreover, we believe that the development and implementation of SIMs may be an opportunity to foster such collaboration, to the extent that SIMs seek to incorporate a state's Medicaid beneficiaries. We recommend that CMMI engage with a diverse group of stakeholders to better understand how SIMs could interact with ongoing program integrity efforts in the 340B program.

#### **D. Rural Communities**

CMMI requests that stakeholders provide input on the question of how to address challenges associated with improving health outcomes in rural communities. BIO appreciates CMMI's specific focus on rural communities, as patients in these areas often face higher hurdles to appropriate care given the realities of their geographical location. In particular, the small patient numbers in rural areas exacerbate the concerns around setting total cost of care targets based on historical data (described in more detail in section I(A)). For example, a relatively small rise in the incidence of a complex, chronic disease in a rural community could more significantly impact the community's ability to meet total cost of care targets than it would a large metropolitan area, which could absorb the increased cost over a much larger patient population. Thus, it is all the more important that CMMI work with individual states to establish safeguards that allow providers to recoup baseline costs required to furnish high-quality care, without which, rural practices are likely to find it difficult to participate in the type of models envisioned by the RFI.

Additionally, CMMI should specifically identify whether a state, which is interested in participating in a SIM, has the data infrastructure in place to capture patient health outcomes and total spending in rural settings accurately and in a standardized manner. Providers in rural communities may face additional challenges to data collection and reporting, due to limited resources or a lack of broadband access, which will need to be overcome before being able to participate in a statewide SIM.

#### **II. Section 1(f): Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?**

BIO appreciates CMMI's recognition that SIMs will need to uniquely fit the local environment(s) of individual states to be effective in decreasing overall healthcare expenditures and improving patient health outcomes. In fact, a one-size-fits-all approach to developing and implementing SIMs would run the risk of ignoring important local circumstances and would prevent the needed flexibility in SIM design to ensure that patient access to appropriate care is not compromised under these models. The need for unique SIMs also engenders the need for flexibility with regard to measuring a state's performance under a specific model.

Specifically, BIO is concerned that attempting to overlay a standardized set of metrics across all SIMs may result in obscuring important aspects of a state's performance,

<sup>9</sup> See HRSA Office of Pharmacy Affairs. FY 2012 Audit Results [10/9/2014], Available here: <http://www.hrsa.gov/opa/programintegrity/auditresults/fy12results.html>; FY 2013 Audit Results [1/7/2014], Available here: <http://www.hrsa.gov/opa/programintegrity/auditresults/fy13results.html>; FY 2014 Audit Results [2/24/2015], Available here: <http://www.hrsa.gov/opa/programintegrity/auditresults/fy14auditresults.html>; and, FY 2015 Audit Results [2/25/2015], Available here: <http://www.hrsa.gov/opa/programintegrity/auditresults/fy15auditresults.html>.

and may give the false impression that comparisons can be drawn across SIMs. To avoid this, we recommend that, rather than CMMI aligning mechanisms of measurement across states with different models in place, the Agency should establish strict standards for defining the patient populations affected, the interventions employed by the SIM, and quality of care and overall cost metrics and outcomes that will be measures at the start of each demonstration. In this way, it will be clear whether information can be compared across models without obstructing the needed flexibility in measurement to ensure it is specific to and meaningful in the context of the individual SIM to which it is being applied. CMMI and states should provide opportunities for stakeholder feedback on individual models to refine these measures, and their implementation, to fit the local circumstances.

**III. Section 1(g): What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?**

In response to the RFI question on the issue of accounting for overlap with existing models, BIO echoes the concerns raised in a recent *New England Journal of Medicine* analysis that noted that the multitude of existing Medicare demonstrations “are reaching a scale at which distortions generated by overlapping models could create real problems” with regard to evaluation efforts.<sup>10</sup> For purposes of SIMs, this can present significant confounding variables that will make it very challenging to accurately interpret what observed effects are the result of the SIM alone, the other demonstration(s) that may be in place, or the combination of elements of the SIM with the elements of another model. The inability to measure the impact of a SIM on account of these confounding variables should give CMMI pause. To overcome this concern, BIO strongly recommends that CMMI work with states interested in establishing a SIM to identify specific patient populations that are not already involved in a demonstration or pilot program, but that are served by multiple payers. These populations would be ideal targets of the type of model envisioned by the RFI and would provide CMMI and the state with opportunities to evaluate the impact of the SIM in a methodologically rigorous manner.

**IV. Section 2(2): Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate?**

BIO appreciates the potential benefits of strict adherence to rigorous scientific methodologies (e.g., randomization) for studying cause-and-effect relationships. However, we believe that the degree of statistical power that such model designs may offer is outweighed by the impracticality and inflexibility of such designs when confronted with realities of patient care, which may differ significantly between states and between regions within a state. Model design elements, like randomization, may unduly risk patient care, which may undermine the goals of a SIM (e.g., to improve patient care and decrease overall expenditures). Moreover, these types of design elements, and randomization in particular, do not necessarily guarantee the similarity of the cohorts that are constructed: for example, randomization may ensure that the same number of patients are included in each cohort, but not that the patients have the same underlying health status, the same incidence of certain conditions (especially chronic, complex diseases), nor that the payer mix is similar across cohort groups (for models that aim to incorporate all payers). Thus, BIO cautions CMMI against using tools like randomization in SIMs unless there is specific evidence to suggest that they would be appropriate.

<sup>10</sup> Robert E. Mechanic, *When New Medicare Payment Systems Collide*, 374 New Eng. J. Med. 1706, 1709 (2016).

**V. Conclusion**

BIO appreciates the opportunity to provide feedback in response to the RFI, and we look forward to working with the CMMI as the Agency continues to consider this type of demonstration program in the future. Please feel free to contact me at (202) 962-9200 if you have any questions or if we can be of further assistance. Thank you for your attention to this very important matter.

Sincerely,

/s/

Laurel L. Todd  
Vice President  
Healthcare Policy and Research



1000 Wilson Blvd., Suite 1825  
Arlington, VA 22209

October 28, 2016

Andy Slavitt, M.B.A.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201  
(Submitted electronically to [SIM.RFI@cms.hhs.gov](mailto:SIM.RFI@cms.hhs.gov))

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Saul Levin, M.D., M.P.A.  
*CEO and Medical Director*

Re: Request for Information on State Innovation Model Concepts

Dear AdministratorSlavitt:

The American Psychiatric Association (APA), the national medical specialty representing over 36,500 psychiatric physicians and their patients, is pleased to provide the following comments to the Centers for Medicare and Medicaid Services (CMS) in response to its Request for Information (RFI) on State Innovation Model (SIM) Concepts. Because of the prevalence of mental health and substance use disorders (MH/SUDs) and associated comorbidities, states have an important role to play in addressing the significant gaps in care for these conditions.

There is much work to be done to increase patients' access to appropriate care that will address their mental health and substance use disorders and related needs. In 2014, about 18% (43.6 million) of adult Americans and 13 to 20% of children and adolescents had a mental illness. 8% (20.2 million) of individuals 12 and older had a substance use disorder.<sup>i</sup> Yet only 40% of adults and 50.6% of children ages 8-15 with a diagnosed mental illness – and only 59% of those with a serious mental illness – received treatment.<sup>ii,iii</sup> Individuals with mental illness often also have extensive non-psychiatric medical needs, which are exacerbated by mental illness, and include cardiovascular disease, diabetes, and obesity. The rate of mortality among persons with mental illness in comparison to those without is startlingly high.<sup>iv</sup> A meta-analysis of worldwide mortality estimates found that the risk of mortality was 2.2 times higher for persons with mental disorders.<sup>v</sup> Most of this early mortality is associated with chronic comorbid conditions.

In light of these significant challenges, the APA is pleased that most states that have received a SIM grant to date have implemented some care intervention to improve the delivery of behavioral health services. However, as the RFI discusses, the types of interventions utilized by states have varied, and there are opportunities for rigorous assessment of specific interventions.

As CMS considers future SIM awards, we offer comments on the following issues:

- Utilizing CMS authority/investment to further adoption of the evidence-based Collaborative Care Model;
- Ensuring robust psychiatrist input into behavioral health integration (BHI) models and other system reforms; and
- Potential focus areas for BHI model testing.

### **Utilizing CMS Authority/Investment to Further Adoption of the Evidence-Based Collaborative Care Model**

The APA urges CMS to utilize the SIM program and its funds to promote and support adoption of models for which a robust evidence-base already exists – and in the case of MH/SUD, the Collaborative Care Model (CoCM). Over 80 randomized controlled trials have shown the CoCM to be more effective than care as usual. Meta-analyses, including a 2012 Cochrane Review, further substantiate these findings.<sup>vi,vii</sup> Economic studies demonstrate that collaborative care is more cost-effective than care as usual, and several evaluations found cost-savings associated with its use.<sup>viii,ix</sup> The largest randomized, controlled clinical trial to date of the CoCM – the IMPACT study involving adults 60+ across 5 states and 18 primary care clinics – found that patients in collaborative care had substantially lower overall health care costs than those receiving usual care.<sup>x</sup> “An initial investment in collaborative care of \$522 during Year 1 resulted in net cost savings of \$3,363 over Years 1-4.”<sup>xi</sup>

Under the CoCM, primary care providers treating patients with common behavioral health problems are supported by a care manager and a psychiatric consultant who help implement effective, evidence-based treatment for common behavioral health problems in the primary care setting. The widespread implementation of the evidence-based CoCM, under both fee-for-service and value-based purchasing/payment systems, could dramatically improve access to effective behavioral health care while at the same time reducing the high health care costs associated with common mental health and substance use disorders.

CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Surgeon General, and the Agency for Healthcare and Quality (AHRQ) have already recognized the CoCM as an evidence-based best practice, and CMS has proposed to cover and reimburse the CoCM under the 2017 Medicare Part B Fee Schedule.

To speed uptake of this model, CMS could make funding available under the SIM for states to:

- 1) Create programs to train primary care practices in the model (including linking them to existing TCPI efforts in this area);
- 2) Provide technical assistance to support needed practice transformation, which includes education and support in redesigning workflows, contracting, hiring of care managers, and quality metric tracking; and
- 3) Institute appropriate reimbursement pathways for care delivered in this model.

### **Ensuring Robust Psychiatrist Input into Behavioral Health Integration (BHI) Models and Other System Reforms**

Based upon input from psychiatrists who are active in state-based behavioral health integration efforts as well as broader delivery and payment system reform, we urge CMS to increase ongoing opportunities for psychiatrists to provide input both at the federal and state level. In relation to the quality metrics that are selected to assess a reform’s success, there are concerns that there are not enough relevant measures being used to assess meaningful improvement in care delivery and health outcomes for MH/SUDs. In cases of broader, system-wide transformation efforts, such as accountable care organizations, we have heard concerns that MH/SUDs are not a central consideration of reforms. This is despite the fact that such disorders can be a major contributor to (and exacerbating factor for) morbidity and mortality, which unfortunately is particularly true for vulnerable populations.

**We urge CMS to include as part of future RFPs and funding arrangements, specific questions and other appropriate features to ensure that input is obtained from psychiatrists and other behavioral health providers.** This type of information should be requested on an ongoing basis and addressing MH/SUDs should be incorporated into the design of new models of care delivery. Such avenues would include public comment periods, and requiring psychiatrist representation on work-groups/task forces/committees engaged in this reform work.

### **Potential Focus Areas for Behavioral Health Integration Model Testing**

As the RFI discusses, there are numerous approaches to addressing MH/SUDs and primary care integration. Unfortunately, most models in behavioral health integration lack the substantial evidence basis of the CoCM. More assessments of these other models are needed. We therefore support CMS making supplemental rewards, as contemplated in the RFI, to support rigorous testing of new models and approaches.

**The APA is particularly interested in identifying the key elements and design features needed to ensure the effectiveness and success of models of co-location and “reverse integration,” particularly those focusing on individuals with severe mental illness (SMI). Numerous governmental and non-governmental entities have identified specific research needs, many of which would be well suited to CMS’ interest in evaluating standardized care interventions.**

The Reforming States Group and Milbank Memorial Fund reviewed the evidence on integrating primary care into behavioral health settings for individuals with SMI, evaluating 12 randomized controlled trials. They concluded that:

- Care management may improve mental health symptoms and mental health-related quality of life for patients with bipolar disorder and SMI ([moderate Quality of Evidence] QOE).
- Fully integrated care and care management improves use of preventive and medical services (moderate QoE) and may improve physical health symptoms and quality of life for patients with bipolar disorder and SMI (low QoE).
- Colocating primary care in chemical dependency treatment settings without enhanced coordination and collaboration does not improve mental or physical health outcomes (moderate QoE).
- All interventions required additional staff, training, and oversight except when intervention staff was dually trained in primary care and substance misuse treatment.”

However, “comparisons across studies to determine key components of BHI interventions for SMI populations are difficult due to few studies targeting this population and a lack of consistent definition of collaborative care management.” CMS could utilize the findings of this evidence review to design a standardized multi-state assessment around delivery of integrated care for individuals with SMI.”<sup>xii</sup>

The Rand Corporation evaluated the Substance Abuse and Mental Health Administration (SAMHSA) Primary and Behavioral Health Care Integration (PBHCI) Grant Program and made specific recommendations for additional research on effective models of primary care delivery in behavioral health settings:

“Conduct a prospective trial of alternative models of integrated care. There are currently several, large ongoing trials of health care innovations including integrated care models. As such, stakeholders in the field could conduct a prospective, comparative effectiveness trial to assess the comparative clinical

impact and costs associated with these models when serving similar and/or overlapping populations of adults with SMI.”<sup>xiii</sup>

The Agency for Healthcare Research and Quality (AHRQ) issued a report on “Future Research Needs for the Integration of Mental Health/Substance Abuse and Primary Care” which included the following points relevant to this RFI:

“What are effective methods of integrating primarycare into specialty mental health practice settings? Studies would include both mental and general health outcome(s) (e.g., obesity and depression). Among adults with serious mental illness seen in specialty mental health settings, what are effective methods of integrating primarycare components such as preventive interventions and chronic disease management, into their mental health care, compared with referral to primarycare?”<sup>xiv</sup>

The Patient-Centered Outcomes Research Institute (PCORI) has also identified mental health and primary care integration as a priority area and has offered the following suggestions:

“Compare the effectiveness of care models that integrate mental and behavioral health care, including substance abuse treatment, into the primary care provided by community health centers and other relevant settings, with the goal of reducing disparities in care (e.g., access to mental and behavioral health services and the diagnosis and treatment of mental and behavioral health conditions) and improving health outcomes among underserved populations, including racial/ethnic minorities, low-income individuals, and rural populations.”<sup>xv</sup>

Thank you in advance for your consideration of our comments. The APA looks forward to working with CMS as it develops additional SIM funding opportunities. If you should have any questions or would like to discuss our comments further, please contact Nevena Minor, APA Deputy Director of Payment Advocacy, at [nminor@psych.org](mailto:nminor@psych.org) or (703) 907-7848.

Sincerely,  
Saul Levin, M.D., M.P.A.  
CEO and Medical Director

<sup>i</sup> Substance Abuse and Mental Health Services Administration. “Mental and Substance Use Disorders.” Available at: <http://www.samhsa.gov/disorders>. Accessed 10/21/2016.

<sup>ii</sup> National Institute of Mental Health. “Use of Mental Health Services and Treatment Among Adults.” Available at: <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml>. Accessed 10/21/2016.

<sup>iii</sup> National Institute of Mental Health. “Use of Mental Health Services and Treatment Among Children.” Available at: <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-children.shtml>. Accessed 10/21/2016.

<sup>iv</sup> Druss, B.G et al. “Mental disorders and medical comorbidity.” Robert Wood Johnson Foundation. Research Synthesis Report No. 21, February 2011. Available at: <http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html>. Accessed 10/21/2016.

<sup>v</sup> Walker, E.R. et al. “Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis.” *JAMA Psychiatry* 72: 334-341, 2015.

- <sup>vi</sup> AIMS Center (Advancing Integrated Mental Health Solutions). "Collaborative Care Evidence Base." Available at: <https://aims.uw.edu/collaborative-care/evidence-base>. Accessed 10/22/2016.
- <sup>vii</sup> Archer J et al. "Collaborative care for people with depression and anxiety." Cochrane Review. October 2012.
- <sup>viii</sup> Gilbody S et al. "Costs and Consequences of Enhanced Primary Care for Depression: Systematic Review of Randomised Economic Evaluations." The British Journal of Psychiatry. October 2006;189:297-308.
- <sup>ix</sup> Glied S et al "Review: The Net Benefits of Depression Management in Primary Care." Medical Care Research and Review. June 2010;67(3):251-274.
- <sup>x</sup> Unützer J et al. "Long-term Cost Effects of Collaborative Care for Late-life Depression." American Journal of Managed Care. Feb 2008;14(2):95-100.
- <sup>xi</sup> Unützer J et al. "The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes." Health Home Information Resource Center Brief. Centers for Medicare and Medicaid Services. May 2013.
- <sup>xii</sup> Gerrity, M. et al. "Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness." New York, NY: Milbank Memorial Fund. 2014.
- <sup>xiii</sup> Scharf D, et al. "Evaluation of the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) Grant Program." Santa Monica, Calif, RAND, 2014.
- <sup>xiv</sup> Carey TS, et al. "Future Research Needs for the Integration of Mental Health/Substance Abuse and Primary Care: Identification of Future Research Needs from Evidence Report/Technology Assessment No. 173." Rockville (MD): Agency for Healthcare Research and Quality. 2010.
- <sup>xv</sup> Patient-Centered Outcomes Research Institute. "List 7: Listed as a PCORI Priority in a Pragmatic Clinical Studies Funding Announcement." <http://www.pcori.org/research-results/how-we-select-research-topics/generation-and-prioritization-topics-funding-5>. Accessed: 10/21/2016.



**Memo**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



**Re:** Center for Medicare and Medicaid Innovation RFI on State Innovation Model Concepts

**Date:** 11/2/16

**From:** Erin Holve, Director Health Care Reform and Innovation Administration

The District of Columbia is committed to transforming our health system to provide better care and smarter spending for healthier residents in the District. We are a proud participant in multiple CMS-driven initiatives charged with reaching these goals and have substantial experience collaborating with CMS (and other federal agencies) to design new Medicaid benefits. With grant support from CMS we have built internal expertise on the various Medicaid legislative authorities, payment approaches, HIT infrastructure, and performance metrics needed to design and sustain new Medicaid benefits that support CMS's goals to link payment to quality. Based on these experiences we are providing input on concepts related to continuing CMS-state partnerships on state-based payment and delivery system reform initiatives.

Our comments provide input on cross-cutting concepts addressed in the Request for Information (RFI), including our perspective on the need for CMS to:

- I. Continue providing strong support for multi-payer delivery and payment reform initiatives while providing flexibility to states;
- II. Streamline requirements to better coordinate the review and administration of multi-payer state initiatives;
- III. Emphasize the importance of social determinants of health as an important component of delivery and payment reform; and
- IV. Continue providing infrastructure support and technical assistance for data collection, sharing, and analysis critical to reform initiatives.

Each of these issues is addressed in greater detail in the sections that follow.

We are pleased CMS has requested input on potential efforts to enhance state-based payment and delivery system reform initiatives and would be pleased to provide any additional information on our programs or responses

***I. Continue strong support for multi-payer delivery and payment reform initiatives while providing flexibility to states***

The high-proportion of DC residents covered by DHCF's programs (approximately 40%) has enabled Medicaid to provide leadership to drive our delivery and payment reforms. Notable achievements include:

- Implementation of a Medicaid Health Home for beneficiaries with severe mental illness in 2016
- The launch of a new Health Home benefit for beneficiaries with physical chronic conditions in 2017;
- Expansions in long term care services to comply with federal home and community based patient-centered service policies; and
- The upcoming launch of new payment methodologies for our FQHCs and nursing homes; and
- Oversight to ensure Medicaid managed care plans fulfill expectations within the final Medicaid Managed Care rule.

As we have developed these programs, support from CMS for state innovation models (SIM) has been critical.

In particular, our Phase II SIM model design award was a foundational effort, bringing more than 500 stakeholders together representing providers, beneficiaries, and local leaders. Together this group successfully articulated a set of shared goals for the District. Our resulting State Health Innovation Plan (SHIP) has been widely disseminated and has already demonstrated it is a valuable tool for facilitating communication and bringing collaborators together around health reform initiatives.

DC has also leveraged technical assistance provided through our SIM grant, Innovator Accelerator Program awards and other federal entities (e.g. Office of the National Coordinator; Federal Administration of Community Living) to identify ways to use our new Medicaid initiatives as paths for providers to qualify as APMs under the Medicare Access and CHIP Reauthorization Act. We see particular value to leveraging Medicaid Health Homes (HH) as one opportunity to work towards a multi-payer model in DC given current interest in Accountable Care Organizations and a desire to align with the quality payment program (QPP).

Furthermore, we appreciate CMS's proposal that participating in HH programs would enable providers to qualify as earning 100% of the "Clinical Practice Improvement Activities" under MIPS. Moving forward, a more standardized pathway to support the transition from health homes to integrated multi-payer model would be valuable to bolster DC's efforts. We see two specific opportunities for the SIM initiatives to enhance our current activities:

1. Engage Medicare providers to educate them about HH as one opportunity to enhance their MIPS score. With support from the SIM initiative, DC could leverage future SIM activities by working with providers in order to align their existing care coordination programs with HH. Further work could be undertaken to align quality measures across programs currently in place. This would enable DC to re-engage key SIM workgroups to consider the impact of MACRA rules

which were finalized after the conclusion of our SIM performance period. Additional work streams would enable us to more directly engage with Medicare payers and providers.

2. SIM can also be used to develop a multi-payer APM strategy. Within DC, Medicaid, Medicare, and one dominant commercial payer make up the majority of the market, but there is very little APM penetration from those payers in DC. With support from SIM initiatives DHCF could work across these payers and provider networks to build the infrastructure needed to promote APMs (e.g. ACOs and bundles) that can be leveraged city-wide. There are substantial ongoing efforts to promote value-based purchasing in DC, however, these are not coordinated at present. Current programs address nearly all market segments, and include: new Managed care value-based purchasing requirements; existing advanced models supported by major commercial private payers; existing Medicare ACOs; an established Children's hospital in the region; interest in emerging ACO arrangements and growing support for 1115 waiver authority to support alternative payment models. SIM support is necessary to help us strategize, organize, and align around all the levers in our market to optimize the impact of state delivery system reform initiatives.

At the same time, these engagements demonstrate there are persistent gaps in knowledge regarding the best approaches to achieve multi-payer alignment in a way that supports providers, patients, and community needs. Access to best-in-class tools and ongoing technical assistance is also needed to facilitate collaboration. Key components of future efforts to develop multi-payer models in states like DC will require several years to build organizational capacity to meet QPP requirements. In addition, grant funding will also be needed to provide technical assistance to state staff and providers in order to support this transition.

While the designs of Medicaid initiatives vary due to the different needs of each state, we request that CMS use the themes of successful Medicaid initiatives to shape future federal partnership and funding opportunities. As part of this effort, clearer linkage or cross-walks between Medicare and Medicaid policies are requested to give states the flexibility to align efforts with the needs of their residents and health-related landscape.

## ***II. Streamline CMS requirements to better coordinate review and administration of multi-payer state initiatives***

While the ACA created CMS's Innovation Center to test innovative models that can transform how care is paid for and delivered, the design and implementation of new models touches many CMS offices including the Medicaid / CHIP Office (MCO); Medicare-Medicaid Coordination Office (MMCO) and the Center for Consumer Information and Insurance Oversight (CCIIO), as well as other federal agencies (e.g. Office of the National Coordinator (ONC)). True and sustainable transformation of a state's health system requires changes to its numerous components--- many of which intersect with parts of CMS's organizational portfolio.

As a participant in multiple CMS-state partnership initiatives, we have faced repeated challenges and delays in enacting new programs due to the explicit and implicit limitations of navigating different CMS offices that manage directed funding streams. On numerous occasions we have received conflicting

information regarding program requirements. In several instances conflicting information and timelines have led to programmatic delays that are the direct result of uncoordinated processes within CMS. Employing an integrated approach to managing federal and state partnerships would provide a holistic approach to system transformation and result in more efficient use of resources at both the state and federal level.

**III. *Emphasize the importance of social determinants of health as an important component of delivery and payment reform***

While the District has one of the highest health insurance coverage rates in the nation, DC has not achieved wide-spread improvements in the health of its residents. According to the Commonwealth Fund Scorecard of State Health System Performance (2015), DC is ranked 51<sup>st</sup> in breast cancer death rates, 50<sup>th</sup> in mortality amenable to health care, and 42<sup>nd</sup> in children who are overweight or obese<sup>1</sup>. Like many other highly urban areas, simply having access to health care services does not translate to better health outcomes. Using provider payments to extend the reach of medical care into the social service world, and vice versa, will enable health systems to accomplish the population-focused improvements envisioned through CMS's value based initiatives.

The literature shows that 10% of a person's overall well-being can be attributed to care delivered in a clinical setting<sup>2</sup>, while the biggest contributor to a person's health is the environment in which he/she lives, works and plays. Public health frameworks described in Healthy People 2020, such as [Public Health 3.0](#), should play a more prominent role in determining the range of services encouraged by providers participating in new value-based programs. Additionally, metrics that track the incorporation of socially-driven services into these programs should be developed and used.

Emphasis on the importance of collaboration between clinical and non-clinical service providers should mirror the strong push to create links between acute hospital and ambulatory care. Similarly, provider-directed technical assistance from CMS should include training that exposes and educates medically-focused providers on the importance of social determinants of health, what they are, and tangible steps providers can take to ensure that their comprehensive approach to care considers their patient's housing, employment, access to nutrition, exposure to violence and other socially-related aspects of well-being.

**IV. *Continue to support infrastructure and technical assistance for data collection, sharing, and analysis critical to reform initiatives***

DC has received support to build HIT infrastructure through its Medicare and Medicaid EHR and Meaningful Use programs, and in the design, development and implementation of HIE through HITECH

<sup>1</sup> McCarthy, Douglas, et. al., (2015) "Aiming Higher: Results from a Scorecard on State Health System Performance, 2015 Edition." Commonwealth Fund. Downloaded from the World Wide Web on September 27, 2016 at [http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/dec/2015\\_scorecard\\_v5.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/dec/2015_scorecard_v5.pdf)

<sup>2</sup> Determinants of Health Model based on frameworks developed by: Tarlov AR. Ann NY Acad Sci 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. JAMA 2008; 299(17): 2081-2083.

funding. However, similar to other states, DC is yet to determine how to integrate and use the vast array of data needed to accomplish the goals set forth in CMS's value-based initiatives.

For multi-payer payment and delivery system reform with alternative payment models, it is increasingly clear that clinical data available in electronic health records will be an important component of outcome measurement. Ongoing financial, infrastructure and technical assistance support is needed from CMS to continue to build state's capacity to merge, validate, and analyze Medicare and Medicaid data, in addition to clinical data and other sources of information related to social determinants of health.



October 31, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: Request for Information on State Model Concepts**

Dear Acting Administrator Slavitt:

The American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACS CAN) (collectively "The Society") appreciate the opportunity to provide comments in response to the Center for Medicare and Medicaid Service's Request for Information on State Innovation Model Concepts.<sup>1</sup> The Society is a nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

The Society strongly supports CMS's efforts to advance access to the delivery of quality health outcomes through the State Innovation Model (SIM) initiative, and recognizes the value that Alternative Payment models have for the goals of the Triple Aim. CMS' SIM initiative should encourage the use of a wide array of health care providers as appropriate, including community health workers who are especially equipped to address ethnic and racial disparities in health care and improving population health by addressing the social, economic and environmental factors that influence health outcomes.

As CMS looks to partner with states on state-based payment and delivery reforms, we urge you to incorporate policies that will improve the health care for individuals with cancer, including those who are newly diagnosed, in active treatment, and/or have completed their treatment. An estimated one in two males and one in three females in the United States will be diagnosed with cancer at some point during our lives.<sup>2</sup> In 2016 alone, an estimated 1.68 million new cases of cancer will be diagnosed in the United States.<sup>3</sup> Individuals with cancer are living longer due to a variety of factors including treatment

<sup>1</sup> A copy of the RFI is available at <https://innovation.cms.gov/Files/x/sim-rfi.pdf>.

<sup>2</sup> American Cancer Society, Lifetime Risk of Developing Cancer, Mar. 23, 2016, available at <http://www.cancer.org/cancer/cancerbasics/lifetime-probability-of-developing-or-dying-from-cancer>.<sup>3</sup>

American Cancer Society, Cancer Facts and Figures 2016, available at <http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf>.

innovations and increased focus on cancer prevention. At the same time, the incidence of cancer increases with age; 86 percent of all cancers are diagnosed in individuals 50 years of age or older.<sup>4</sup>

### **Prevention**

As CMS develops the SIM initiative, we urge you to require states to provide additional coverage of preventive services. Research has shown that up to half of all cancers can be prevented by not using tobacco, eating a healthy diet, being physically active, managing weight, and getting recommended cancer screenings and vaccines.<sup>5</sup> Enacting policies that encourage the adoption of a healthier lifestyle will not only reduce the risk of developing cancer, but will also reduce the risk of developing other chronic diseases (such as heart disease and diabetes) as well. Preventive services are a good value because it can be less expensive to prevent cancer than to treat it.

While the Affordable Care Act requires coverage of services that receive an “A” or “B” rating by United States Preventive Services Task Force (USPSTF) by most commercial plans, there is concern that the USPSTF recommendations are not being fully realized. HHS should provide clarity regarding the full range of services that should be covered as part of a comprehensive service as recommended by the USPSTF. For example, clarity is needed to ensure that coverage is being provided for all forms of tobacco cessation treatment, including in-person individual, in-person group, and telephone-based individual counseling as well as all tobacco cessation medications approved by the U.S. Food and Drug Administration for that purpose, with no cost-sharing and prior authorization.

In the Medicare context, ACS CAN has strongly urged CMS to clarify that beneficiaries are not subject to co-insurance for screening colonoscopies that include polyp removal or biopsy. In addition, CMS should provide additional clarity regarding the extent to which a beneficiary would receive comprehensive screenings and preventive services at no cost. For example, under practice guidelines an individual whose fecal occult blood test (FOBT) or fecal immunochemical test (FIT) is positive is required to receive additional screenings – usually a follow-up colonoscopy – to determine if the initial test was a true- or false-positive. We urge CMS as part of the SIM initiative to ensure that all screenings up to the point of diagnosis are considered a preventive service and thus no additional cost-sharing would be imposed on the beneficiary.

We note that the USPSTF guidelines focus exclusively on primary preventive services. We urge CMS to require participants in the SIM initiative to cover more secondary preventive services, and other services that promote prevention. Secondary prevention – i.e., preventing cancer recurrence, exacerbation of symptoms during treatment, or treatment complications – is also extremely important in improving health outcomes, and reducing costs. Counseling and programs for weight management, physical activity and nutrition can not only prevent cancer, they can also prevent cancer recurrence, and help

<sup>4</sup> Id.

<sup>5</sup> Doll R, Peto R. The causes of cancer: quantitative estimates of avoidable risks of cancer in the United States today. *J Natl Cancer Inst* 1981 Jun;66(6):1191-308; Calle EE, Rodriguez C, Walter-Thurmond K, Tun MJ. Overweight, Obesity, and Mortality from Cancer in a Prospectively Studied Cohort of U.S. Adults. *N Engl J Med* 2003; 348:1625-1638; Hu FB, Willett WC, Li T, Stampfer MJ, Colditz GA, Manson JE. Adiposity as Compared with Physical Activity in Predicting Mortality among Women. *N Engl J Med* 2004; 351:2694-2703; Danaei G, Vander Hoorn S, Lopez AD, Murray CJL, Ezzati M. Causes of cancer in the world: comparative risk assessment of nine behavioral and environmental risk factors. *Lancet* 2005; 366:1784-93.

cancer patients currently in treatment manage their symptoms. Palliative care services provided early in a cancer patient's treatment can alleviate side effects and lead to better treatment outcomes.

### **Patient Navigation**

Research has shown that effective care coordination at each phase along the continuum of cancer care is vitally important for patients.<sup>6</sup> Conversely, a lack of care coordination for cancer patients has been shown to result in lower quality of care for cancer patients.<sup>7</sup> Patient navigator services can help patients follow through with additional tests after screenings and complete treatment regimens – and can be tailored to patient populations that are in particular need of this help. The National Patient Navigation Research Program, a trial of over 10,000 women and men with abnormal cancer screening and over 3,000 patients with diagnosed cancers and precancerous conditions, found that patient navigation had a positive effect on reducing delays in care and increased by 20 percent the proportion of patients completing diagnostic care.<sup>8</sup> Other research has shown that health systems that used patient navigators had better patient health outcomes and reduced health care expenditures through lower hospital readmissions or admissions, improved timely diagnostic resolution and prescription drug adherence.<sup>9</sup>

We urge CMS to require participants in the SIM initiative to provide coverage of navigation services, including the delivery of current and customized diagnosis and treatment information that ensures patient understanding and informed decision making; the connection of patients to useful and available community services; consistent support and monitoring of care plans; and, an overall determination of the needed services to be used to remove barriers to care including transportation, lodging, health insurance, cultural, and language barriers. Such services are critical as individuals transition from primary care, to specialty care, and then back to primary care.

### **Post-Treatment Planning**

For patients with chronic illness transitioning from specialty care back to primary care there is a critical need for chronic disease self-management care planning. In the case of cancer patients, this kind of post treatment planning is commonly referred to as a survivorship care plan. For cancer patients who have successfully completed treatment, survivorship care planning will entail scheduling required screening tests, physical therapy if necessary, oncology nutrition services, access to and an understanding of maintenance drugs, and a plan for health promotion (diet, exercise, weight management) to reduce risk of late effects of cancer (e.g., Endocrine problems). We urge CMS to

<sup>6</sup> Hewitt M, Greenfield S, Stovall, eds. Committee on Cancer Survivorship: Improving Care and Quality of Life, Institute of Medicine, National Research Council. *From Cancer Patient to Cancer Survivor: Lost in Translation*. Washington, DC: National Academies Press; 2006.

<sup>7</sup> Bowles EJA, Tuzzio L, Wiese CJ, et al. Understanding High-Quality Cancer Care: A Summary of Expert Perspectives. *Cancer*, 2008; 112(4): 934-942.

<sup>8</sup> Freund K, Battaglia T, Calhoun E, et al. Impact of patient navigation on timely cancer care: the patient navigation research program. *Journal of the National Cancer Institute* 2014;106(6) doi: 10.1093/jnci/dju115.

<sup>9</sup> Jandorf L, Stossel LM, Cooperman JL, Graff Zivin J, Ladabaum U, Hall D, Thélémaque LD, Redd W, Itzkowitz SH. Cost analysis of a patient navigation system to increase screening colonoscopy adherence among urban minorities. *Cancer* 2013 Feb 1; 119(3):612-20; Donaldson EA, Holtgrave DR, Duffin RA, Feltner F, Funderburk W, Freeman HP. Patient navigation for breast and colorectal cancer in 3 community hospital settings: an economic evaluation. *Cancer* 2012 Oct 1; 118(19):4851-9.



mandate that participants develop a post-treatment plan with beneficiaries who have received specialized services (e.g., beneficiaries who have completed their cancer treatments).

### **Conclusion**

On behalf of the American Cancer Society and the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the request for information on state innovation model concepts. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at [Anna.Howard@cancer.org](mailto:Anna.Howard@cancer.org) or 202-585-3261.

Sincerely

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Control  
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**Colorado State Innovation Model Office Response to  
The Center for Medicare and Medicaid Innovation  
Request for Information on State Innovation Model Concepts**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS

**ACTION:** Request for Information (RFI)

**Response from the Colorado State Innovation Model (SIM) Office**

The Colorado State Innovation Model (SIM) office welcomes the opportunity to respond to the Center for Medicare and Medicaid Innovation's (CMMI) Request for Information (RFI) on State Innovation Model concepts. As a Round Two Model Test recipient, Colorado is currently nine months into the implementation of our State Health Innovation Plan, which seeks to improve the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 % of state residents by 2019.

In the last year, the SIM office has overseen the successful launch of the first of three cohorts of primary care practices and four community mental health centers that will receive practice transformation support to help them transition to care delivery models that integrate physical and behavioral health. The SIM office has also engaged with the Colorado Multi-Payer Collaborative (the Collaborative), a self-funded and self-governing group of private and public healthcare payers that originated as part of the Centers for Medicare & Medicaid Service (CMS) Comprehensive Primary Care initiative (CPC) – to develop a multi-payer framework that will strengthen primary care by incorporating the integration of primary care and behavioral health services. Earlier this year, six private payers and Health First Colorado (formerly Colorado Medicaid) signed a Memorandum of Understanding (MOU) with the SIM office, outlining their commitments to support SIM practices through the following mechanisms: value-based payments, data sharing, aligned quality metrics and other accountability targets.

Although the SIM office is encouraged by some early program successes (i.e., 97% of the 93 practices in Cohort 1 successfully met quality measure reporting requirements for the second quarter), we have identified certain areas of our model that could be improved based on the roll out of Cohort 1 and stakeholder feedback. In addition, the healthcare landscape in Colorado has changed significantly since the SIM application, which we must consider. For example, the announcement of the Comprehensive Primary Care Plus initiative (CPC+), release of the final Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and consolidation in the health insurance market all have implications for the success of the Colorado SIM initiative. As we prepare for implementation Year 2 and the onboarding of a second cohort of 150 practices, we are taking time to strengthen and further define our care delivery model, and taking steps to ensure greater alignment between payment models and practice transformation activities and goals. Many of the issues we are grappling with speak directly to the topics included in the RFI. The SIM office therefore offers the following responses to the RFI, based on experiences to date and the lessons we have learned in implementing a statewide care delivery and payment reform model.

## SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

We are seeking comment on two pathways, consistent with our two prior guidance documents on multi-payer models inclusive of Medicare:

### 1. A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation

### 2. Support statesto align with existing Medicaremodels

Colorado has been engaged in an ongoing conversation with CMS regarding Medicare participation in the SIM initiative in conjunction with public and private payers participating the Collaborative. Since the initiation of these discussions in the fall of 2015, the healthcare landscape has continued to evolve at the federal level with the announcement of the CPC+ and finalization of MACRA and state level with consolidation of the health insurance marketplace. The SIM office and the Collaborative have continued to explore the development of a multi-payer payment model to support practices participating in SIM. This RFI announcement provides the opportunity to expand this dialogue to include other key stakeholders around the potential establishment of a statewide multi-payer model that would include Medicare as a payer.

The Collaborative's work around a multi-payer model has been focused on identifying common foundational elements within current payment arrangements that could serve as a baseline for future models. The Collaborative initially formed through the Comprehensive Primary Care initiative (CPC), and has expanded to include SIM and CPC+—providing a focus on alternative payment arrangements that incent the adoption of patient-centered medical home (PCMH) care delivery models and strengthen comprehensive, advanced primary care in the state. As part of the evolution of the Collaborative, payers have committed to build on these initial efforts and provide value-based payments to support the integration of primary care and behavioral health services through SIM, an element that Colorado would like to incorporate into a multi-payer model.

While the PCMH model is well-established in Colorado, historically and through CPC, SIM, and CPC+, a statewide multi-payer model would need to expand the current scope beyond primary care and behavioral health providers and facilities to include other components of the healthcare system- such as hospitals and specialists (i.e., pediatricians) that have been ineligible to participate in some previous initiatives. In addition, the state also has several large and active accountable care organizations (ACOs), which would need to be incorporated into a comprehensive payment model.

Colorado looks forward to working with CMS and CMMI to determine a path for pursuing Medicare participation in multi-payer alternative payment models (APMs) for the SIM initiative and beyond. Our responses to the RFI illustrate the various factors influencing this decision.

## QUESTIONS

- 1) *What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?*

Colorado is very interested in working with CMS to pursue a state-based, multi-payer healthcare delivery and payment framework that would facilitate the transition of eligible clinicians to Advanced AMPs under the Quality Payment Program (QPP). The state is engaged in multi-payer care delivery and payment reform efforts through initiatives such as CPC and SIM, which provide a strong foundation for the continued transformation of our healthcare system. The development of a statewide multi-payer model, which would include Medicare as a payer and be accountable for the health of populations, represents an exciting next step in this evolution that will require discussions between multiple stakeholders. These conversations are in the early stages, but the SIM team in Colorado looks forward to engaging in this work with state and federal partners, and appreciates the technical assistance and support that CMMI will be able to provide as we develop a comprehensive strategy for moving forward.

- a. *What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?*

### **CHALLENGES IN ACHIEVING ALL-PAYER ALIGNMENT**

States face a variety of challenges in achieving all payer alignment. In Colorado, these include a highly competitive marketplace and a diverse array of care delivery and payment models.

#### **Colorado marketplace**

Colorado has a highly diverse and competitive marketplace. In 2014, approximately 440 health insurers were active in Colorado, with the 10 largest health insurers representing 74% of the market.<sup>1</sup> There is a significant amount of variation and competition among health plans with small, local non-profits, sophisticated integrated systems, and the largest, publicly-traded health insurance organizations all competing for market share. This diversity of actors—each with varying resources, capacities, and strategies at their disposal—presents challenges to the adoption of value-based payments across payers.

In addition, the implementation of the Patient Protection and Affordable Care Act's health insurance market reforms during the last two years has affected coverage trends in the state. In 2015, the number of Coloradans who reported receiving insurance through their employer fell to 50.9% from 57.7% in 2009. Of those with job-based coverage, employees receiving benefits from a large employer (companies with 50 or more workers) increased by 3.5%, while those covered through a small employer fell by 12%.<sup>2</sup> The number of private employers opting to self-insure has fluctuated during the past decade. That number was 40.6% in 2008 and 41.2% in 2012 and then fell to 34.7% in 2013 and went to 39.5% in 2014.<sup>3</sup> The Center for Improving Value in Health Care, which administers Colorado's All Payer Claims Database, estimates the self-insured commercial market represents approximately 30% of covered lives in the state.<sup>4</sup>

<sup>1</sup> Colorado DOI Health Cost Report

<sup>2</sup> Colorado Health Access Survey (CHAS), 2015

<sup>3</sup> Colorado DOI Health Cost Report

<sup>4</sup> Colorado All Payer Claims Database FAQs for Self-Insured Rule Change. Center for Improving Value in Health Care. Available at <http://www.civhc.org/getmedia/1d504402-8acb-4fc6-a812-a7c49007960f/Self-Funded-FAQs.pdf.aspx/>.

Trends in public coverage are also shifting. In 2015, about one out of three Coloradans (34.2%) was covered by public insurance, which represents an increase from 24.2% in 2013. The sharpest growth has been in Medicaid, which has more than doubled in size since 2009 and now covers 19.9% of the state's population.<sup>5</sup> The number of Medicare beneficiaries in the state has also increased from 9.7% in 2009 to 12.9% in 2015.<sup>6</sup> However, this population is expected to increase dramatically in the next decade as Colorado has one of the fastest growing senior populations in the U.S. The state demographer's office forecasts the number of Coloradans aged 65 and older will increase by 61 % between 2010 and 2020,<sup>7</sup> with 155 Coloradans turning 65 each day.<sup>8</sup> By 2040, Colorado's 65+ population will represent 19 % of the state's total population (close to 1.5 million people).<sup>9</sup>

#### Diversity of healthcare delivery and payment models

Colorado was an early adopter of the PCMH, launching one of the first multi-payer medical home pilots in 2009. This three-year project included five private payers and the Cover Colorado, the state's high-risk pool, and 16 primary care practices, which received additional compensation and individual coaching and learning collaborative support to achieve at least level 1 PCMH recognition by the National Committee for Quality Assurance. The success of this demonstration laid the ground work for future PCMH initiatives, including the Colorado Medical Home Initiative, a collaborative effort coordinated by the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF) to promote the medical home approach, Colorado Medicaid's Accountable Care Collaborative (ACC), and Colorado's selection as one of seven regions for CPC.

Colorado's SIM initiative was designed to leverage previous payer and provider efforts to transform primary care delivery in the state, and strengthen comprehensive, person-centered, team-based care approaches by including the integration of physical and behavioral health.

In addition to the wide adoption of the PCMH model, a significant number of public and private ACOs and ACO demonstrations are operating in the state. As of August 2016, seven ACOs are participating in the Medicare Shared Savings Program (MSSP), and two are in the ACO Investment Model. Health First Colorado's ACC program blends elements of PCMH and ACO models with incentives structured around patient-centered care delivery and care coordination, in and across the medical neighborhood. In addition, several commercial payers have ACO arrangements.

The existence of multiple payment models in the state, at various stages of maturity, is a reflection of the diversity of payers and practices in the state. As noted, Colorado has a range of private payers (regional and national) with different business strategies and priorities; many have implemented enterprise-specific payment models with practices in their networks, which contains features of PCMH models, ACOs, or both. Healthcare providers and practices also vary in terms of organizational structure. Colorado has historically had few large, multi-specialty physician groups,

<sup>5</sup> CHAS; This reflects the 2014 increase in eligibility under the ACA, with nearly all Coloradans at or below 138 percent of the federal poverty level (FPL) now eligible.

<sup>6</sup> CHAS

<sup>7</sup> *Aging in Colorado*, July 2012. Colorado Department of Local Affairs, State Demography Office. Available at [www.colorado.gov/demography](http://www.colorado.gov/demography).

<sup>8</sup> *Transitions in Age and Increasing Diversity*, Fall 2015. Colorado Department of Local Affairs, State Demography Office. Available at [www.colorado.gov/demography](http://www.colorado.gov/demography).

<sup>9</sup> Colorado Population 1970-2040, Infographic. Colorado Department of Local Affairs, State Demography Office. Available at <https://demography.dola.colorado.gov/demography/infographics/#infographics>.

with more physicians in small, one to three member practices. While some physicians have joined independent practice associations or aligned with management service organizations that contract with health plans, many are also selling their practices to hospitals or entering into direct employment contracts. Thus providers in the state are also differentially positioned in terms of their ability and preference to engage in PCMH or ACO models.

#### Successes to date

Despite these challenges, a majority of Colorado's commercial payers, including Medicaid, have come together voluntarily to collaborate and maximize the pace of transformation and the effects of their own investments through multi-payer processes. The Collaborative's commitment to building on initial efforts to expand and support primary care transformation throughout the state is evidenced through continued payer participation and investment in federal initiatives, including SIM, CPC+, enterprise-specific approaches, and the data aggregation project.

Through the Collaborative, payers have built a strong foundation for the statewide transformation of care delivery and payment systems in Colorado. For example, payers have agreed to work together to use common definitions and shared metrics across initiatives, which are consistent with April 2015 and November 2015 CMS guidance. Through participation in CPC, Colorado has been able to strengthen and expand the state's adoption of the PCMH model among payers and providers in keeping with the primary care functions outlined by CMS (risk-stratified care management, access and continuity, planned care for population health, patient and family caregiver engagement, and comprehensiveness and coordination).

Payers in the state have also made significant advancement in data sharing with practices, another important principle for PCMH models outlined in the November guidance. Unique to Colorado, payers have aggregated their claims data and made it available to practices through *Stratus™*, an online tool that is usable at the point of care. These payers are also financing practice access to the tool. Additionally, CMS is participating in data aggregation by providing Medicare Part A and B data to *Stratus™* for CPC practices, as well as financial support for this aggregation and analytics tool. Practices are able to access data across the medical neighborhood, manage population health and integrate with their clinical data, and view total cost of care through *Stratus™*, which provides a unique and unprecedented opportunity to test and measure reduction of total cost of care across the medical neighborhood for CMS beneficiaries.

Colorado's SIM proposal specifically sought to leverage the time, energy, and resources payers and providers had invested in transforming primary care delivery, and build upon these efforts to include the integration of physical and behavioral health. In developing practice transformation activities and requirements for SIM, Colorado drew upon CPC milestones to create the Framework for the Integration of Whole Person Care. The clinical quality measures selected for SIM were also taken from the basic CPC dataset, and supplemented with a sub-set of metrics focused on behavioral health. Finally, Colorado SIM is seeking to expand payer achievements around data sharing with practices under CPC by offering data aggregation and analytics capacity available through *Stratus™* to practices participating in SIM.

While CPC, SIM, and CPC+ have and will continue to serve as focal points for Colorado's efforts to transform care delivery and payment approaches, the success of these and future federal initiatives could be enhanced by additional support from CMS, as outlined below.

## **NEED FOR CMS ASSISTANCE AND SUPPORT**

CMS could offer a variety of support to ensure the success and sustainability of current and future initiatives to achieve the Triple Aim and to develop payment models that meet the requirements of Advanced APMs under the QPP. These include:

- **Medicare participation in SIM and the Collaborative**

Medicare's participation in the Collaborative is an essential ingredient in SIM and is critical to meeting the goals of the initiative. A multi-payer approach (particularly one that represents all Colorado payers) will hasten delivery system transformation in a way that CMS cannot do alone. Medicare's active participation in the Collaborative focused on SIM is essential. The vigorous multi-payer environment of Colorado is a critical component to achieving CMS' goals. Medicare represents the single largest payer in many primary care settings. Medicare's participation will serve as a synergistic accelerator to the transformation efforts of CMS and all of the private payers in Colorado. Having a consistent representative from CMS participate in Collaborative meetings is also important; Colorado seeks to engage with CMS not just as a participating payer, but as a partner at the table.

Enhanced payment for primary care services by individual payers has been shown to help improve the availability of care and initiate individual transformation processes. These enhanced payments may take different forms for payers based on their particular programs and payment methodologies. However, as noted in the Health Care Payment and Learning Action Network's recently released "Primary Care Payment Models Draft White Paper," practice transformation efforts benefit their entire patient population, not just a subset of it, and practices do business with multiple payers.<sup>10</sup> The Collaborative is dedicated to transforming not only care delivery, but also the manner in which care is paid for, and the way in which success is measured. Participating payers are committed to a systems transformation approach whereby the provision of high-value, integrated, whole person care is supported by an integrated investment by multiple payers in infrastructure, quality and efficiency. Tying payment from multiple plans to advanced primary care will accelerate adoption of cutting-edge integrated care delivery of Colorado's SIM model. And, Medicare is the key payer that will create a "tipping point" in most practice groups and system.

- **Access to timely Medicare data**

- *Datasharing with providers*

CMS recognized the need for robust data sharing between payers and practices to help practices coordinate care and take actionable steps to reduce unnecessary utilization and total cost of care for their patients in the November 2015 guidance. However, simply sharing data is not enough; providers must be equipped with the tools and resources needed to interpret and analyze data, and incorporate results into practice workflows to improve care delivery, manage the health of patient populations, and control costs.

In Colorado, payer efforts to provide CPC practices with aggregated cost and utilization data were greatly bolstered by CMS's decision to participate in *Stratus*™. The inclusion of timely Medicare data in this tool allows practices to view a much larger portion of their patient

<sup>10</sup> Primary Care Payment Models Draft White Paper, 10/19/2016. Health Care Payment and Learning Action Network Primary Care Payment Model Work Group. Available at <https://hcp-lan.org/groups/pcpm/pcpm-draft-whitepaper/>.

populations, increasingly its utility and effectiveness. The processes of executing the necessary data sharing agreements between CMS and Best Doctors, Inc., the administrator of *Stratus*<sup>™</sup>, and submitting and incorporating data files were not without difficulties, but represents a significant success for data aggregation efforts in Colorado. CMS' financial support was also invaluable.

Currently, CMS' participation in *Stratus*<sup>™</sup> is slated to end when CPC comes to a close in December of 2016. However, CMS' continued participation in data aggregation efforts is critical to the success of Colorado SIM, CPC+, and other future initiatives. Therefore, the Colorado SIM joins payers in requesting CMS' continued support of Stratus by:

1. Sharing Medicare claims data;
2. Including behavioral health data;
3. Providing financial resources to support aggregation; and
4. Providing technical and financial support to expand provision of the aggregation tool to 80% of Colorado practices by 2019.

- **Engagement with EHR vendors, certified health IT**

The extraction and reporting of electronic clinical quality measures (eCQMs) from electronic health records (EHRs) has been identified as a priority use case for Colorado SIM's health information technology strategy, and will be critical to providers' abilities to successfully participate in advanced APMs under the QPP. However, as the SIM Office has been working with providers to report CQMs for SIM, we have learned about the challenges many practices face in collecting and reporting quality measures due to limitations in their EHR systems. For example, practice's ability to calculate metrics using a rolling year reporting period, the preferred approach for using data for quality improvement, is precluded by EHR vendors that wipe the previous year's data from their systems at the end of the calendar year. EHR vendor willingness and capacity to add measures – such as the behavioral health measure for anxiety developed by SIM in conjunction with Mathematica – is also variable.

Colorado and other states could benefit from a continued leadership role from CMS and ONC in working with EHR vendors to increase accountability and compliance with certification standards, and to increase the usability and interoperability of EHR data. Continued leadership at the federal level will support providers in the adoption and use of certified health IT, required under CPC+ and MACRA.

- **Policy changes**

Certain changes in federal regulations could facilitate the adoption and expansion of care delivery models that increase quality and outcomes. A key example, of particular relevance in Colorado, involves federal rules for sharing healthcare information. Clarification of privacy and confidentiality laws around health information exchange, including treatment for substance use disorders, would help eliminate real and perceived barriers to integrated care delivery.

- **Measure alignment**

The need to align measures across federal initiatives and programs is a constant theme in conversations with providers, payers, and other stakeholders in Colorado. Providers cite reporting burden as a primary concern in continued engagement in reform initiatives; the need to report "similar but not identical" measures through different reporting systems is a



key source of reform fatigue and provider burnout. Payers report similar concerns in adjusting their own systems to meet the needs of different initiatives.

Continued federal leadership in aligning metrics across initiatives and programs will help states develop advanced APMs by providing common accountability targets across payers and providers. The frameworks outlined in the final MACRA rule, and the Health Care Payment and Learning Action Network (HCPLAN) national data collection effort, serve as useful benchmarks to guide such efforts outside of the context of any single initiative. Yet these frameworks need to allow continued flexibility for payers and providers to adopt measures and other accountability targets that drive improved care delivery while controlling costs.

- b. *What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?*

Factors that have contributed to the success of multi-payer delivery system reforms in Colorado to date include:

- **Strong executive leadership** – Governor John Hickenlooper has taken an active leadership role in pursuing initiatives that promote and advance the health of state residents. The Governor outlined a vision for building a comprehensive, person-centered statewide system that delivers the best care at the best value to help Coloradans achieve the best health in *The State of Health: Colorado's Commitment to Become the Healthiest State* report that was released in 2013. The plan calls upon public and private organizations, as well as Colorado citizens, to work together to specific targets – measured by 21 metrics across 18 initiatives – across four strategic focus areas: prevention and wellness; coverage, access, and capacity; system integration and quality; and value and sustainability. This plan provides a guiding framework for current and future efforts to transform the state's healthcare system.
- **Multi-payer participation** – As noted, public and private payers came together to establish the Collaborative, a self-governing, self-funded group that has been instrumental in driving care delivery and payment reform in the state. The Collaboration includes all payers, both public and private, in the state working with a range of stakeholders to drive transformation through finance and care delivery changes.
- **Stakeholder engagement** – Colorado has a strong history of stakeholder engagement and collaboration around healthcare initiatives. SIM offers a recent example of this cooperative spirit; in preparing the model test application, the SIM team convened a variety of large and small meetings with approximately 175 stakeholders representing consumers, providers, insurers, agencies, academia, technology, business and behavioral health who provided in-depth feedback and direction on the State Healthcare Innovation Plan. The SIM office continues to engage with more than 130 stakeholders through a governance structure that includes eight workgroups, a steering committee, and an advisory board.
- **Investments in health information technology** – Colorado has secured federal, state and community funding to build and strengthen local HIT infrastructure and test innovations. Through grants and strategic planning efforts, Colorado state agencies and non-state agency

partners have implemented sustainable programs to promote HIE and improve care coordination among providers through HIT efforts. Colorado has two regional HIEs – the Colorado Regional Health Information Organization (CORHIO), and Quality Health Network (QHN) – and numerous community HIE-type programs with focused information exchange between organizations. Colorado also has many health initiatives working towards enhanced data capture and information exchange in order to improve care, reduce costs and improve health outcomes.

- c. *What are the unique challenges of state Medicaid programs in readying themselves to offer advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program?*

State Medicaid programs face several challenges in attempting to change their care delivery and payment models in ways that meet the criteria for advanced APMs. These include, but are not limited to:

**1) Funding**

Sufficiency

With the sunset of ACA Section 1202, Medicaid typically has lower levels of primary care reimbursement than other payers. Providers question whether there is room in the Medicaid rates for any level of financial risk or accountability to outcomes.

Title XIX scope

To achieve improvement in outcomes for Medicaid clients, providers will inevitably need to find mechanisms to address the non-medical needs of clients, including the social determinants of health. Currently Medicaid benefit packages and associated federal funds are highly medicalized. States need to leverage financing strategies and additional flexibility under Title XIX to make primary care reforms truly successful.

**2) Balancing adequate access and provider accountability**

Due to fiscal constraints, payment reforms tend to rebalance available funding rather than create new funding to invest in primary care. This means that poor performers will get less reimbursement which makes them even less likely to take Medicaid clients. When access is already a challenge, losing providers that are not bad, but not good enough to earn higher reimbursement can be damaging to clients.

**3) Disparate capacity for change in the provider community**

Colorado has significant geographic diversity. Providers in rural areas have a different ability to change business processes than providers in urban areas. Many rural providers lack the ability to invest in infrastructure changes necessary to move the bar on metrics significantly. Given the high number of rural providers in Colorado, an entirely different payment reform strategy is needed, and not just one that exempts rural providers from accountability.

**4) Accounting for a bifurcated delivery system**

In Colorado Medicaid, behavioral health is provided under a managed care delivery system. Physical health is predominantly provided under fee-for-service. Colorado is leveraging

APMs to support efforts to integrate care, but this is especially challenging when the financial incentives and delivery systems are not well aligned.

**5) Special populations**

Medicaid is the primary payer for several special populations, such as individuals with intellectual disabilities. Colorado also has a large number of children; in fiscal year 2014-2015, 421,025 children without disabilities were enrolled in Medicaid. APMs and additional provider risk have to be matched with accountability that ensures the needs of special populations are never sacrificed. For example, it will be important to avoid incentives to discharge clients, who are “difficult” for the sake of hitting metrics that increase total reimbursement.

**6) Authority**

To receive Title XIX funds, CMS approval is always required and a clear source of regulatory authority is always needed. It is still not clear which authority should be used for specific payment reforms such as CPC+. States need flexibility with and support from CMS to implement APMs in a manner that does not jeopardize federal financial participation (FFP).

**7) Multi-payer coordination**

As previously noted, many payers are active in Colorado. APMs that do not use similar metrics and incentive structures will not be effective as providers do not have capacity to pursue too many different initiatives at once. Multi-payer coordination is difficult with so many actors who have to balance a need to remain competitive. The Collaborative offers a forum in Colorado for creating payer alignment around metrics and accountability structure, but reaching consensus among the diversity of actors still presents a challenge. Members are addressing these challenges through the continued engagement of private payer representatives and Medicaid, a neutral facilitator (selected by the payer), and strategic coordination across regional projects. CMS’ full participation in the Collaborative, through a designated representative and financial support for its maintenance, would greatly assist in advancing current and future multi-payer reforms.

**8) Stakeholder buy-in**

Provider level reforms are challenging because it is a very difficult task to engage clinicians and practices in the design and implementation of reforms. They can suffer from reform fatigue when there are too many. Practices have to choose between participation in public forums and seeing clients; many practices don’t have the capacity or resources to do both. However, if they are not engaged, it is unlikely they will produce the results intended from the reforms. This problem is exacerbated by the multi-payer issue above.

*2) CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.*

*a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies?*

*Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.*

#### Financial incentives

During the next three years, SIM will evaluate the effects of value-based payment models on the integration of behavioral health and primary care, as well as the effect on population health. The Collaborative is working to implement strategies in Colorado that align with the care delivery approach developed by the SIM office in achieving primary care and behavioral health integration. Payers will use good faith efforts to contract with the practices selected for this initiative, and the practices will be held accountable for meeting quality metrics, cost and utilization metrics, and transformation milestones.

At the time the SIM initiative was launched it was not anticipated that CPC+ would be introduced; therefore, many payers identified SIM as a vehicle to continue the work accomplished in CPC. The payment approaches used for SIM currently vary by payer: in some cases, payers are continuing and/or expanding CPC payment models to SIM practices; in others they are employing enterprise-specific approaches with SIM practices; and in others they have modified or expanded existing models. The Collaborative is developing a model payment framework for SIM that outlines the common, foundational elements across payer approaches. While the framework is intentionally specific to SIM, it will help orient and inform future discussions about the development of a statewide multi-payer model that would include Medicare as a payer.

#### Additional Tools & Resources

Additional tools and resources payers and providers will need under value-based payment arrangements include:

- 1) **Data** - Primary care practices need actionable data relating to total cost of care and utilization to support practice transformation effort, improve care quality, and control costs.
- 2) **Attribution** – Payers and providers need a clear understanding of attributed patient lives at the practice and provider level.
- 3) **Analytics** – Payers and providers need tools that effectively analyze and apply data to inform care delivery and payment.
- 4) **Aligned measures** – Measurement alignment across initiatives is essential to reduce reporting burden and provider reform fatigue or burnout.
- 5) **Accountability mechanisms** – Payer efforts to progressively align the requirements for value-based payments and APMs will facilitate providers' capacity to participate.
- 6) **Payer and practice expectations** - Open dialogue and congruent expectations among payers and providers are essential to the success of APMs.

*3) Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.*

Stakeholders in Colorado, including public and private payers and providers, currently have access to data through a variety of sources. The state's all-payer claims database (APCD), which began operations in 2012 with three years of historical claims data from the largest 7 commercial payers plus Colorado Medicaid, has expanded to include claims data submissions from more than 20 payers, including Medicare FFS, Medicare Advantage plans, Medicaid, and commercial payers. In addition to the APCD, Stratus™ – the data aggregation solution procured by payers participating in the Collaborative – provides point-of-care information to practices participating in CPC to make changes from the patient to the system level. Pilot efforts are currently underway that would expand this tool to include clinical information. Colorado also has an HIT infrastructure that includes two regional HIEs, which collectively provide coverage of the entire state, to facilitate the exchange data.

Colorado SIM is currently working with partners across the state, in conjunction with the Office of eHealth Innovation, to identify strategic technology initiatives that will not only increase access to data, but will also promote data-driven change and facilitate collaboration between payers, providers, and the public health system. SIM will build upon existing synergies between public and private agencies to help advance a comprehensive HIT strategy that improves the secure and efficient use of data and information technology to improve health system performance, increase the quality of care, and decrease costs for all state residents.

CMS's support of and participation in these efforts – through the timely provision of Medicare data, participation in data aggregation and analytic efforts, and financial support – will play a critical role in ensuring the success of these endeavors.

## SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

### QUESTIONS

1. *CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).*

Colorado has used various levers – including the state's role as a regulator, payer, purchaser, and convener – to foster and drive healthcare innovation. The state's Medicaid program, administered by the Department of Health Care Policy and Financing (HCPF) has played a leading role in driving innovation, through participation in federal initiatives and independent actions. In May 2011, the department launched the Accountable Care Collaborative (ACC), a program designed to transform Colorado Medicaid from a system that relies on fee-for-service payment for episodic care into a system that encourages and rewards integrated, person-centered care that leads to good health outcomes for Colorado's Medicaid clients while lowering costs for the state. The ACC is central to the department's mission to increase access to healthcare and improve health outcomes while showing careful stewardship of financial resources. It is aligned with the Triple Aim created by the Institute for Healthcare Improvement and adopted by CMS.

The ACC program has grown to statewide enrollment of 899,596 Medicaid or Health First Colorado clients (more than 70% of all Colorado Medicaid clients), as of June 2015. There are about 520

practices, statewide, functioning as primary care medical providers (PCMPs) within the program.<sup>11</sup> Clients enrolled in the ACC receive physical health services through a primary care case management system. Providers are still paid for each medical service they deliver; however, the ACC has also introduced new payments tied to increased value and health outcomes to encourage the adoption of client-centered, whole-person approaches to care. Seven Regional Care Collaborative Organizations (RCCOs) work at the local level to support ACC clients and providers by providing medical management and care coordination, and ensuring clients receive coordinated, comprehensive, person-centered care, and other non-medical supports as needed to overcome barriers to getting appropriate care. In addition, RCCOs are responsible for provider network development, provider support, and accountability and reporting.

While the ACC forms a strong foundation for Colorado Medicaid's transformation efforts, the department has taken extensive steps to ensure the alignment of ACC goals and objectives with those advanced by CMS through federal initiatives. The Department is a member of the Multi-Payer Collaborative, and is a participating payer in CPC, SIM, and CPC+. To support SIM, the RCCOs are incentivizing a total of 88 of the cohort-1 practices statewide with funds from the program's pay-for-performance pool, and the department plans to continue to support future cohort practices. Looking forward, SIM will be aligned with the evolving ACC program to ensure coordinated support for practices as they continue to work towards improving health outcomes and experience of care while containing costs.

Through the SIM initiative, Colorado has also engaged the Department of Personnel Administration (DPA), which oversees the state employees' health benefit plan, regarding the use of value-based payments in state employee health contracts. The State Employee Health Plan covers roughly 30,000 state employees and dependents through a self-funded plan administered by UnitedHealthcare and a fully-insured Kaiser Permanente product, which represents a powerful lever for expanding APMs.

The Colorado Division of Insurance (DOI) is a strong partner and supporter of Colorado SIM, and state efforts to transform care delivery and payment. As payment models continue to evolve, the DOI will play a critical role in ensuring the proper regulatory protections are in place to guard against over-extended risk, insufficient pooling, and market failure, and in developing regulations or guidance that could accelerate the adoption of successful approaches.

### **SECTION III: STREAMLINED FEDERAL/STATE INTERACTION**

CMS seeks input on how to improve both coordination among related federal efforts in support of state-based delivery and payment reform efforts (e.g., workgroups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

### **QUESTIONS**

<sup>11</sup> Supporting a Culture of Coverage, Accountable Care Collaborate: 2015 Annual Report. Colorado Department of Health Care Policy and Financing. Available at:

<https://www.colorado.gov/pacific/sites/default/files/Supporting%20a%20Culture%20of%20Coverage%20Accountable%20Care%20Collaborative%202014-15%20Annual%20Report.pdf>

1. *CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?*

#### Engagement in transformation efforts

Colorado has a long history of engagement in initiatives at the state and federal level that have been aimed at healthcare delivery transformation. Currently, Colorado is the recipient of a Round 2 State Innovation Model Test Award and is a Practice Transformation Network (PTN) for the Transforming Clinical Practice Initiative (TCPI). Colorado is also one of the seven regions participating in CPC and was selected as one of the 14 regions to participate in CPC+. In addition, seven ACOs are participating in the MSSP and two are part of the ACO Investment Model. Outside of the Innovation Center, Colorado is taking part in AHRQ's EvidenceNOW Initiative, and received a planning grant for SAMHSA's Certified Community Behavioral Health Clinics (CCBHC) demonstration program.

#### Results of engagement

Colorado's participation in federal initiatives has resulted in tangible improvements in care quality and cost savings. As noted in a recent blog posting by Dr. Patrick Conway, CMS Principal Deputy Administrator and Chief Medical Officer, CPC's second round of shared savings results showed that nearly all practices (95 %) met quality of care requirements, and four out of seven regions – including Colorado – realized net savings (after accounting for the care management fees paid) and will share in those savings with CMS. CPC practices showed lower than expected hospital admission and readmission rates, and favorable performance on patient experience measures. In addition, CPC practices' performance on eQMs surpassed national benchmarks, particularly on preventive health measures.<sup>12</sup>

At the state level, the ACC has also demonstrated substantial results in achieving care delivery and cost targets. During FY 2014–15, the department estimates that the ACC achieved medical-expenses savings of \$121,288,048, with net savings totaling \$37,682,795, after accounting for all administrative expenses. This was achieved by coordinating client care, reducing duplicative and unnecessary service use, and shifting the focus of the health system away from uncoordinated episodic care to primary and preventive care. In addition, data suggest that the ACC had a positive effect on service utilization patterns. ACC clients who had been in the program for longer than six months were more likely to seek timely follow-up care after being discharged from the hospital and were more likely to receive vital prenatal and postpartum care. At the same time, ACC clients with more than six months in the program were less likely to receive services at an emergency room, receive high-cost imaging services, or be readmitted to a hospital within 30 days of discharge as compared with those enrolled for six months or less. Department analyses show that the rate of receipt of annual well-child visits and chlamydia screenings increased for clients who were enrolled for more than six months, when compared with those enrolled for six months or less. Finally, results

<sup>12</sup><https://blog.cms.gov/2016/10/17/medicares-investment-in-primary-care-shows-progress/>



from the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey conducted during FY 2014-15 indicate that client satisfaction remains high.<sup>13</sup>

Overall, Colorado's participation in federal initiatives have allowed engagement with a diversity of providers, and patients, throughout the state. As of October 2016, 206 providers in 71 primary care practices, serving a total of 450, 641 patients were participating in CPC.<sup>14</sup> Colorado SIM will recruit 400 primary care practices during its three-year implementation period, reaching an estimated 1,600 providers and 3,057,348 beneficiaries.<sup>15</sup>

## *2. How can CMS/HHS better align in order to support state delivery system reform efforts?*

While multiple, concurrent initiatives offer additional resources, support, and opportunities for engagement, they also contribute to the complexity of an already variegated and dynamic healthcare landscape in the state. The need for alignment – not only philosophically, but at a programmatic and operational level – across initiatives has become an increasingly important consideration in project planning and implementation. For example, in Colorado stakeholders have made a concerted effort to align clinical quality measurement reporting across federal and state initiatives. Colorado SIM selected measures that were used for CPC in an effort to reduce payer and provider burden. However, because CMS is not providing SIM with data submitted through the CPC portal, practices participating in both initiatives must still log into different sites, and report the same measures, separately. The ability of CMS to share metric data gathered for CPC and CPC+ with SIM would reduce administrative burden on payers, providers, and program staff.

While achievement of the Triple Aim serves as a unifying foundation for many transformation efforts, the differences and similarities between initiatives has also become a source of confusion, and in some cases additional burden for practices and providers trying to take advantage of these opportunities. Clear descriptions of each initiative, including the goals, objectives, and expected benefits of participation, would be of great benefit, as would tools that allow providers to compare and contrast initiatives.

Colorado is very interested in working with CMMI to work through the various issues involved in initiative alignment. The announcement of CPC+, which shares many similarities with our SIM model, emphasizes this need. The interrelated goals and objectives of the two initiatives creates natural synergies that could accelerate and magnify one another – creating a true benefit for practices, providers, and payers electing to participate in both. This would also mitigate the risk of practices making a choice between participating in CPC+ or SIM, and accentuate the message that the initiatives are intended to be complementary and not competitive. However, the opportunity for practices to accelerate their transformation efforts by participating in both may be missed if alignment cannot be achieved around certain program reporting and participation requirements. For example, the learning collaborative activities for both initiatives will share many commonalities; requiring practice staff to participate in sessions covering similar topics will place an avoidable

<sup>13</sup> Department of Health Care Policy and Financing's response to the Joint Budget Committee's Legislative Request for Information #7, November 2015.

<https://www.colorado.gov/pacific/sites/default/files/Health%20Care%20Policy%20and%20Financing%20FY%202015-16%20RFI%207.pdf>

<sup>14</sup> <https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/colorado.html>

<sup>15</sup> Colorado State Innovation Model Application for Funding for Test Assistance, July 21, 2014.



burden on providers. Alignment around clinical quality metric reporting, or the sharing of metric data between CMS and the SIM office, would similarly reduce provider burden. The SIM office is committed to working with CMMI to align SIM and CPC+, and potential future initiatives, in a manner that reduces provider burden while maintaining program integrity.

With leadership from the Governor's office, public and private stakeholders in Colorado continue to support multiple federal initiatives. However, the state looks to CMS leadership to help with this alignment, and ensuring that individual initiatives do not pull payers or providers in different or competing directions. Colorado is excited to engage with CMS and CMMI and chart a course that will maximize state and federal resources in support of healthcare transformation. We appreciate CMS' assistance and willingness to discuss Medicare participation in SIM, and consider a statewide multi-payer model that would allow Colorado providers to receive the incentives associated with advanced APMs through the QPP.

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.



Purpose: The Centers for Medicare & Medicaid Services (CMS) is seeking input on the following concepts related to state-based payment and delivery system reform initiatives:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive;
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

## Summary

Washington State has made substantial progress towards health transformation and the movement to value-based payments. We continue to spread and scale our existing efforts by utilizing our state health care contracts (Medicaid and state employees), our newly awarded Medicaid Transformation Demonstration Project, and multi-payer initiatives in alignment with Medicare. To accelerate statewide transformation, CMS support is needed in the following areas:

- Allow for flexibility in Medicare models to adapt and align with state-initiated models, i.e., customize MACRA QPP and other Advanced APMs requirements to HCA's existing health transformation efforts like common measure set, shared decision making, and quality improvement model approach.
- ☐ Provide flexibility at the federal level for innovations in payments to Federally Qualified Health Centers (FQHCs), Rural Health Centers and Critical Access Hospitals.
- ☐ Assist with health information technology efforts including providing Investments in data aggregation and/or infrastructure at the state level, and additional funding to support data reporting among provider groups.

## Introduction/Overview

The Washington State Health Care Authority (HCA) purchases health care for 2.2 million Washington residents through two programs — Washington Apple Health (Medicaid) and the Public Employees Benefits (PEB) Program. We work with partners to help ensure Washingtonians have access to better health and better care at a lower cost. As the largest health care purchaser in the state, and the lead state agency on the State Innovation Model (SIM)-supported Healthier Washington Initiative (Healthier

## HCA's Response to CMS' Request for Information on State Innovation Model Concepts

Washington), we are grateful for the opportunity to respond to this Request for Information on State Innovation Model Concepts from the Centers for Medicare & Medicaid Services.

As directed by the legislature, HCA has set the course for Washington to advance value-based payments and financially integrate physical and behavioral health. We have set ambitious goals to drive 90% of state-financed health care payments into value-based arrangements by 2021. To achieve this goal, the state is using its purchasing power to drive payment and delivery system reform through its Medicaid and public employee contracts.

Washington is closely tracking national movements and initiatives, including active participation in the Health Care Payment & Learning Action Network (LAN), with the aim of standardizing signals across the health system. For example Dorothy Teeter, HCA's director, sits on the LAN Guiding Committee and is an active member of the LAN Purchaser Affinity Group (PAG). We believe that Washington has taken great strides as a state to drive transformation and is seeking support from our federal partners to accelerate progress towards a revitalized and transformed health care system.

### HCA Achievements

Through the SIM Test Grant and various state-based investments, Washington has made significant progress towards health system transformation which we hope to build upon through future initiatives. State-wide, Washington has brought together communities to leverage incentives, align with state programs, and engage the social and community sectors that impact health in order to drive towards improved population health. Early work in this arena has supported providers in adopting team-based care. We are investing heavily in analytics to shape, inform, and drive our purchasing strategies.

Successes to date include:

- ☐ Washington State has seen the 3<sup>rd</sup> largest decrease in the uninsured population, from 14.0% to 6.6%<sup>1</sup> since the implementation of the Affordable Care Act (ACA). While we have successfully moved more individuals into health care coverage, we still face a multitude of challenges, including variation in care, affordability, transparency, and quality. Nevertheless, this provides an opportunity for the state to invest in health care payment and delivery system transformation to bring about a system that delivers quality at an affordable price and ensures the most appropriate care is delivered in a timely fashion.
- ☐ [Washington Statewide Common Measure Set](#)<sup>2</sup>
  - Since 2014, Washington State has worked to develop a legislatively-mandated statewide common measure set to serve as the foundation for health accountability and measuring performance.
  - A starter set of 55 measures was approved in 2015 by the Governor-appointed Performance Measure Management Committee. This collection of 55 nationally-vetted measures has broad support throughout the State's health care.
  - Reporting is currently used to identify variation throughout the state, and sends a clear market signal about expected performance.
- ☐ Payment Models 1 and 3 launched

<sup>1</sup><http://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>

<sup>2</sup><http://www.hca.wa.gov/about-hca/healthier-washington/performance-measures>

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- Payment Model 1: Close to 100,000 individuals are now receiving care through the Apple Health(Washington's Medicaid and CHIP program) program that financially integrated – physical and behavioral health. This whole-person approach to care offers better-coordinated care for patients and more seamless access to needed services.
- Payment Model 3 (LAN category 3b): Over 11,000 public employees and their dependents are receiving care through the Accountable Care Program (ACP). Under this new benefit option, offered through two provider networks (Puget Sound High Value Network and the University of Washington Accountable Care Network), providers are delivering integrated physical, behavioral health, and substance use disorder services. Each network has assumed financial and clinical accountability for a defined population of public employees. The two-sided risk arrangement sets reimbursement based on financial, clinical quality, and member experience targets, as calculated by a HCA-designed Quality Improvement Model (QIM) that accounts for performance and improvement. The 19 quality measures included in the contracts were drawn from the Washington Statewide Common Measure Set, and each network has agreed to care transformation principles and standards of care based on recommendations from the Dr. Robert Bree Collaborative (Bree Collaborative). The Bree Collaborative is a statewide public-private consortium established in 2011 by the Washington State Legislature “to provide a mechanism through which public and private health care stakeholders work together to develop best practice recommendations for health care procedures where there is substantial variation in practice patterns and/or high utilization trends that do not produce better care outcomes.”<sup>3</sup>
- [Accountable Communities of Health\(ACHs\)](#)<sup>4</sup> bring together leaders from multiple sectors around the state with a common interest in improving health and health equity. As ACHs better align resources and activities, they improve whole person health and wellness. There are nine ACHs covering the entire state. While still early in their development, ACHs have taken steps to transform health at the local level:
  - ACHs have taken first steps in collaboration and community engagement by establishing governance bodies and working towards multi-sector engagement.
  - The ACHs have established regional priorities and developed projects to meet the particular needs of their geographic area.
  - ACHs are working to establish sustainability and building a strong foundation for active collaboration on local health improvement projects.
- Data is essential to achieving the Triple Aim of better health, better care, and lower costs, and through Healthier Washington, we have created our [Analytics, Interoperability, and Measurement \(AIM\) team](#). AIM will work collaboratively across state agencies and public and private sector partners to break down data-related silos, address long-term needs for health data management solutions, services, and tools, and serve as a key tool to implement population health improvement strategies around Washington State.
  - AIM provides support to the ACHs by establishing dashboards to identify high priority health projects and providing technical assistance on those projects.
  - AIM is also providing technical assistance to development of alternative payment models and integration of behavioral and physical health.

<sup>3</sup> <http://www.breecollaborative.org/>

<sup>4</sup> <http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach>

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- ☐ The [Practice Transformation Support Hub](#)<sup>5</sup>, managed by the Washington State Department of Health, will accelerate the dissemination and implementation of new and existing practice change supports and assist providers with the transition to value-based care.
  - The Practice Transformation Hub has contracted with Qualis Health, a designated Quality Improvement Organization (QIO), to provide one-on-one provider support to assist with the transition to value-based payments.
- ☐ [Centers of Excellence \(COE\) for a Total Joint Replacement \(TJR\) Bundle](#).<sup>6</sup> HCA created a COE program to support bundle payments, starting with for a TJR bundle payment program offered to state employees in January 2017. Virginia Mason Hospital & Medical Center (VMMC) will serve as the TJR bundle COE. VMMC uses evidence-based best practices as recommended by the Bree Collaborative and will assume financial risk for preventable surgical complications and infections. This COE differs from Medicare-led bundled payment programs as it is built on a prospective payment approach. This approach was developed based on feedback from providers in Washington State, and it builds on existing efforts. For example, VMMC has been a designated TJR COE under the Pacific Business Group on Health bundle program since 2013.
- ☐ Through [Shared Decision Making](#)<sup>7</sup>, we are working to empower people to share in the decision-making when it comes to their own health and the health of their families.
  - Washington State is the first state to certify patient decision aids, tools that can help people engage in shared health decisions with their health care provider.
  - The four patient decision aids provide health care consumers access to reliable sources of information to engage their health care providers on important decisions.
- In the spring of 2016, HCA issued its Paying for Value Survey targeting provider and payer organizations in Washington State. This survey builds on a previous survey HCA administered in 2015 to gauge providers' and payers' progress towards implementing value-based payments and to identify barriers impeding desired progress. Results showed that most payers and providers are still largely reliant on fee-for-service payment infrastructure, with only 18% of responding providers' revenue and 30% of responding payers' payments tied to value. Encouragingly, the percentage of providers and payers engaged in value-based arrangements has increased since the 2015 survey, indicating progress and movement away from the status quo system based on volume and drive towards value-based payments and delivery system transformation. Additionally, each of the nine health plans responding to the survey reported that they currently utilize at least a subset of quality measure from the Statewide Common Measure Set, demonstrating a positive sign in our drive for standardized performance measurement.
- ☐ We now have an agreement in principle with CMS to accelerate our state aims through an 1115 [Medicaid Transformation Demonstration Project](#) (The Demonstration). The Demonstration will further accelerate and support our efforts to improve the health and care delivered to our state's Apple Health population.

<sup>5</sup><http://www.hca.wa.gov/about-hca/healthier-washington/practice-transformation-support-hub>  
<http://www.hca.wa.gov/about-hca/hca-chooses-virginia-mason-center-excellence-total-joint-replacement>

<sup>7</sup><http://www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making>

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- ☐ To better define how we will accomplish these ambitious goals, HCA has released the HCA VBP Roadmap.<sup>8</sup> The Roadmap utilizes the LAN framework and establishes targets of VBP attainment for the Medicaid and Public Employee Benefit programs.

We have made great progress in engaging payers and providers throughout the health care system, but have not reached the tipping point to obtain full, statewide participation in transformation. Going forward, we strive for alignment between federal initiatives and state-led initiatives (i.e., MACRA, Medicaid and state employee purchasing, waiver demonstration), to send a unified signal throughout the health system. We want to build upon our existing efforts to reach the critical mass necessary to transform the broader health and health care system.

### SECTION 1: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

CMS recognizes that there are multiple pathways to achieving this vision, and is interested in public input on ways to support states in developing the operational and infrastructure capacity needed to implement a multi-payer model that includes Medicare and could be an Advanced Alternative Payment Model, regardless of which pathway they pursue.

*Input: on concepts for a potential future state-based initiative that would support states to implement broad scale, multi-payer delivery and payment reforms to support providers entering models that could qualify as Advanced APMs*

Pathway 1: A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation

Pathway 2: Support states to align with existing Medicare models

HCA is interested in pursuing a state-specific multi-payer model (Medicare, Washington State financed health programs (Medicaid and state employee benefit program), and private payers) to send one consistent message to the delivery system. HCA embarked on its own customized path a few years ago in response to low provider interest in participate in federal Medicare payment and reform initiatives. Under a state-specific multi-payer model, HCA will continue to spread and scale elements of current state-led payment and delivery models already implemented by a number of delivery systems in Washington State, including, but not limited to:

- ☐ Washington Statewide Common Measure Set
- ☐ Care transformation strategies based on Bree Collaborative Best Practice Recommendations
  - HCA's Quality Improvement Model or a similar model that rewards quality improvement and attainment
- ☐ Shared decision making using Washington State certified patient decision aids

<sup>8</sup>[http://www.hca.wa.gov/assets/program/vbp\\_roadmap.pdf](http://www.hca.wa.gov/assets/program/vbp_roadmap.pdf)

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Our substantial existing efforts towards a state specific multi-payer model would be enhanced by the integration of Medicare. Leveraging Washington State's efforts and providing flexibility within multi-payer model guidelines would ensure a consistent message throughout the state's health care system.

### QUESTIONS

1. *What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of population?*

- Supporting providers with the transition into value-based payments arrangements, specifically Advanced APMs under MACRA is a key activity under SIM AY3 and the Medicaid Transformation Demonstration Project.
- We are building the Practice Transformation Hub<sup>9</sup> to assist providers entering into new, risk-based alternative payment models. The Practice Transformation Hub has contracted with Qualis Health, a designated Quality Improvement Organization (QIO), to provide one-on-one provider support to assist with the transition to value-based payments. In January 2017, the Hub is launching a web-based research portal with value-based payment resources for providers.
- Not only do we want to assist with providers with the transition to value-based care, but we want to help them maximize QPP payments under MACRA, whether under MIPS and or Advanced APMs track. We will concentrate future efforts to align our current initiatives (i.e., common measure set, shared decision making) with MACRA requirements. At the same, we are eager to have Medicare as a partner to transition eligible clinicians toward Advanced APMs, especially if states are provided the flexibility to customize to align with existing state efforts for health system transformation.

a. *What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?*

- HCA is committed to engaging all payers across the state of Washington in an effort to align clinical guidelines for providers, standardize performance measurement, and transition the delivery system away from fee-for-service and towards a value-based purchasing system. To date, HCA has had limited success in its capability to effect change throughout the broader commercial payer market until recently. One potential reason posed is readiness of payers to participate in multi-payer efforts. Nevertheless, in all of our contractual relationships with payers through our Medicaid and Public Employees Benefits programs we are advancing common standards for performance measurement and care transformation principles, and promoting those standards and principles to other provider and payer stakeholders.
- While we have made significant progress as a state in driving towards alignment, critical challenges remain that must be addressed in order to fully realize statewide transformation. These challenges include:

<sup>9</sup> <http://www.hca.wa.gov/about-hca/healthier-washington/practice-transformation-support-hub>

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- Provider fatigue resulting from the multitude of initiatives, expectations, and communications in development and implementation
- Misalignment in the financing structure and rules for health plan enrollment between Medicaid and Medicare programs, particularly for the dual eligible population
- Access to reliable and complete claims and clinical data sets across multiple payers and provider organizations. This type of data is critical for population health management and accelerated adoption of alternative payment models.
- Limitations to sharing health information under federal privacy regulations.
- We are confident that we can overcome these, and other challenges, with CMS' assistance:
  - CMS should allow for state-based customization of federal programs and initiatives, empowering states like Washington to leverage and build upon the many foundational elements of SIM and other transformative initiatives.
  - CMS should invest in critical infrastructure needed to support providers in the transition to value-based payments and delivery strategies, including data aggregation and interoperable EHRs.
  - CMS should seek stronger alignment between the financial arrangements for the Medicaid/Medicare dual eligible population and create space for innovation within the payment and care delivery for this population.
  - CMS should work with states, particularly HCA AIM division to streamline Medicare data transmission and utilization process.

*b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?*

- Successful multi-payer delivery system reforms are reliant on many factors:
  - Robust IT infrastructure with diverse capabilities
  - Strong state and market leadership
  - Consistent messaging to the provider community across dominant payers, including Medicaid and Medicare
  - Alignment of care transformation principles and performance measurement
- The closer commercial payers, self-insured employers, provider organization, and federal programs can align on these characteristics, the more likely multi-payer reforms are to succeed and spread in scale. Additionally, CMS should provide the following:
  - Clear guidance around how state-based payment models, including Medicaid programs, align with the Advanced APM framework under MACRA.
  - Focus on facilitating multi-payer alignment in Washington State by allowing flexibility in Medicare programs.
  - Allow states, particularly SIM states, to leverage state-based initiatives in Advanced APMs to ensure common signals are sent across the statewide delivery system.



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*c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Programs? And what resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?*

- Medicaid reimbursement for FQHCs and RHCs is defined at the federal level. CMS work closely with states who want to move APMs forward with these critical provider groups.
- Many rural health care providers, particularly FQHCs and behavioral health and long-term services and support providers, are heavily reliant on Medicaid, yet they lack the ability to invest in the infrastructure necessary for participation in APMs. CMS should assure adequate IT support and funding for FQHCs and RHCs and behavioral health and long-term services and support providers. Approved provider TA funding on MACRA may not be sufficient.
- SIM has provided much needed resources to Washington State to build analytic and data aggregation infrastructure through the AIM program. Nevertheless, additional funding and support are needed for long-term sustainability and statewide application. CMS should consider providing additional funding support through any future state-based initiatives to expand the capacity of AIM to support population-based efforts, including funding for data aggregation and/or infrastructure.

*d. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?*

- Any new state-based models from CMS should include an appropriate planning period, followed by a realistic implementation and performance period. Further, CMS should be very clear about expectations for evaluation. In total, a reasonable timeframe for a new model would span 4-5 years, depending on the scope and size of the proposed model. Washington State's SIM experience has already revealed important learning about developing and implementing a widespread state-based initiative:
  - Planning is a critical step, and in light of a rapidly-changing health care environment, states must be given appropriate flexibility to innovate, adapt, and make necessary programmatic changes necessary for successful implementation.
  - Multi-stakeholder alignment takes time and its importance cannot be understated when pursuing statewide models of accountability and standardization.
- A new state-based model from CMS should provide the following timeframe:
  - *Planning period of 1-2 years.* Building collaborative partnerships and aligning payers in the commercial, Medicaid, Medicare, and state-financed space takes time. Allowing for

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sufficient time to plan, adjust, and course-correct is essential to a successful planning period.

- *Performance period of 4-5 years.* Effective statewide transformation takes time, particularly when success is reliant on multi-payer collaboration. A performance period of this length would more realistically allow states to make early adjustments and provide a more effective and realistic evaluation period.
- Longer planning and performance periods would better-support states to align with MACRA and synchronize concurrently developing state-based reforms.

*e. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated*

- Washington's SIM evaluation is being led by an expert team based out of the University of Washington in Seattle, WA. So far this arrangement has worked well, since UW is local and has a firm understanding of Washington's health care market. CMS should allow states to assist in selecting the evaluation method and team to ensure common frameworks while allowing appropriate latitude for customization. Additionally, state and federal evaluation efforts should be aligned to avoid duplication of efforts and burden to stakeholders, as well as ensure efficient rapid-cycle and impact evaluation.

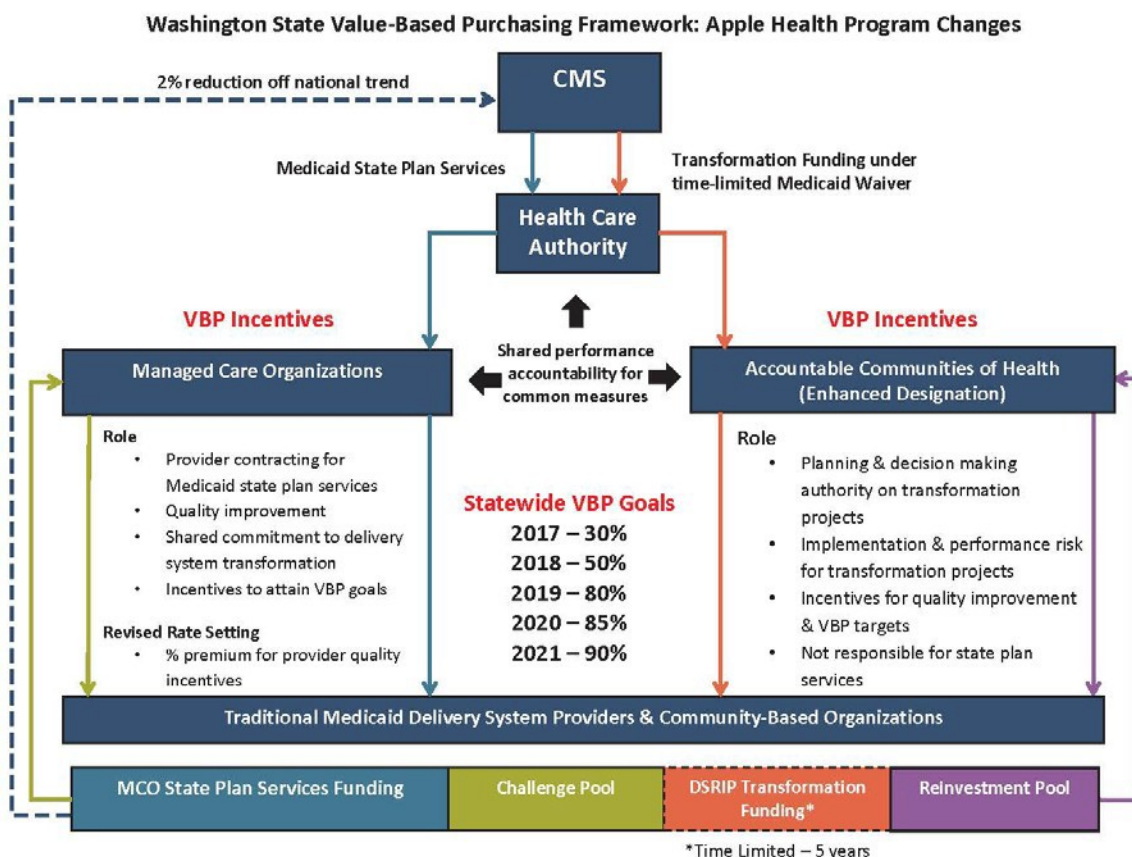
*f. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?*

- HCA launched an Accountable Care Program for state employees in January 2016, and plans to launch a Total Joint Replacement (TJR) bundle and Center of Excellence program for state employees in January 2017. Both programs differ in their approach from Medicare-led programs.
- One provider in Washington did voice concern over the different Medicare APMs and pointed to a Robert Mechanic article. In his New England Journal of Medicine article "When new Medicare Systems Collide" Robert Mechanic points out the potential consequences of implementing multiple APMs at the same time.
- We will monitor both programs closely and will take appropriate action if there are adverse effects. We will share any learnings with the federal government.

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2. *CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.*
  - a. *Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.*
    - HCA's Accountable Care Program under PEBB (its state employee plan) is built on a two-sided risk arrangement, with providers held accountable for cost and quality for a defined patient population. This payment model is reliant upon both clinically integrated networks hiring a data aggregator to consolidate claims and clinical information to calculate quality metrics and having solid HIT infrastructure in place. Both networks under contract with HCA in this payment model have invested heavily in building the capacity to operate in such an arrangement.
    - Starting in January 2017, Washington State's Apple Health MCO contracts will require a growing portion of premiums be used to fund direct provider incentives tied to attainment of quality. To ensure quality and performance thresholds are being met, HCA will withhold an increasing percentage of plan premiums, starting at one percent in 2017, to be returned based on achieving a core subset of metrics from the statewide common measure set. HCA will use the same measures in all provider VBP arrangements.
      - Additionally, through use of time-limited funding under the Medicaid transformation demonstration, MCOs will be able to earn financial incentives for achieving annual VBP targets (described further in the visual below). In 2018 and each year thereafter, the MCOs' accountability for each of these new contract components will grow progressively.
      - Finally, the Apple Health program changes include the creation of a "challenge pool" to reward exceptional managed care performance and a "reinvestment pool" to provide similar regional incentives for exceptional performance attributable to the broader participants in an Accountable Community of Health.
    - In order to drive broad health system adoption of payment reform, large employers and other purchasers of health care need sufficient incentives to change their purchasing strategies. Funding for infrastructure and the use of incentive payments to identify and harness necessary resources (e.g. collaborative purchasing, sharing Chief Medical Officer expertise) would facilitate broader participation of purchasers in transformative payment reforms.

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b. *How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?*

- Clinical-community linkages are paramount to effective population health management and improvement, especially in rural and American Indian communities. Public health and social services, however, are often practically and financially separate from the clinical world. In order to break down barriers and realize a unified health system, incentives and payment structures must encourage cross-communication and coordination between clinical and community services. Washington is pursuing this through its nine Accountable Communities of Health.

- One clear way to better align incentives is to provide states assistance in adopting more population health metrics and move away from disease-specific measures.

c. *How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?*

- Patient attribution methodologies (PCP selection or prospective analyses), aligned performance measurement, and multi-payer data aggregation are critical to effective population health management.

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- Attribution: often, providers face unnecessary complexity and inconvenient burdens when they are forced to navigate varying attribution methodologies across their contractual relationships. In order for providers to realistically accept responsibility for large populations, attribution methodologies must be consistent.
  - Performance measurement: providers are asked to report on far too many measures from multiple sources, many of which are duplicative across payers but framed differently or constructed with different language and/or targets. Standardization of performance measurement is key, and CMS should support Washington State's efforts to align performance measurement by broad adoption of the Statewide Common Measure Set.
  - Data aggregation: providers are simply unable to manage patient populations across various payers without efficient and actionable data aggregation. This necessary infrastructure is also costly to develop. CMS should consider additional funding for broad data aggregation tools and support providers, particularly behavioral health providers, in the adoption of EHRs.
3. *Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.*
- a. *To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?*
- The Washington State Legislature has passed authorizing legislation for a mandatory, statewide All-Payer Claims Database (APCD). The Washington State Office of Financial Management (OFM) is the state designated lead on the APCD. OFM has initiated a contract for a mandatory APCD, a successful bidder was identified, and a contract was executed. This mandatory APCD will include pricing data and is expected to be self-sustaining after start-up. The APCD is expected to be fully functional by the end of 2017.
  - In Washington State, we currently have some ability to compute benchmarks and to monitor cost trends. Washington has a voluntary APCD created by the Washington Health Alliance (WHA), a statewide health improvement organization. WHA publishes the Community Checkup, a report which details delivery system performance using measures from the Washington Statewide Common Measure Set. This report profiles breakdowns including state, county, Accountable Communities of Health, and medical groups, clinics, and hospitals. The 2016 report is being expanded to include a broader reach of data, more detailed reporting, and an interactive data dashboard.
- Do states have integrated Medicaid and Medicare data?*
- The Research and Data Analysis division (RDA) within the Washington Department of Social and Health Services (DSHS) has access to Medicare data for those dual eligible for Medicaid

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and Medicare. RDA reports out on health risk scores for Medicaid clients through their PRISM application. The PRISM application identifies high risk clients for health home enrollment; to calculate performance measures; and to identify gaps in care.

- The HCA AIM program, which is funded through the State SIM grant, is seeking access to Medicare data for all eligible Medicare enrollees to inform alternative payment models, SIM grant evaluation, and other potential uses. CMS could improve this lengthy and costly application process by simplifying and streamlining the process and providing more technical assistance and guidance for completing the application.

*b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?*

- Real-time feeds to providers and provider networks are essential for improved care and successful payment and delivery transformation. Further, price and performance transparency will promote accountability and population health improvement.
- Currently, Washington State's RDA has created an integrated client data base built on claims and some assessment data for Medicaid clients that links to housing, criminal justice, and social service data. Using this integrated data source, RDA will be publicly reporting on some aggregate social, educational, and economic measures related to the Medicaid population on a regional basis. Data are not provided at the provider level at this time. The dual Medicare data that is currently available to RDA has restricted uses, specifically for care coordination and program integrity.
- The Washington Department of Health (DOH) collects population and survey data from a variety of sources to be able to report out on population health, mostly at the state and sometimes county level. DOH has created an interactive dashboard to report population health measures, but these are not broken down by health plan.
- By incorporating value-based purchasing methods, in its Medicaid managed care contracts, HCA is tying payment to improvements in quality. This process is being further supported by strategic investments, using HITECH funds, in provider electronic reporting and a centralized clinical data repository.

*c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?*

- HCA has successfully transitioned to T-MSIS and will be able to complete backlogged submissions by the end of 2016.
- HCA received T-MSIS production approval from CMS on October 3, 2016. Under this approval HCA has the ability to submit all T-MSIS files in the required format. As a part of the pre-production testing with CMS, CMS' contractor reviewed the accuracy and reliability of data fields and HCA has passed all pre-production testing. Due to the transition to T-MSIS, HCA has 20 months of backlogged submissions. HCA submitted a catch-up file schedule to CMS. Commitments include starting the 20-month file submissions begin on October 17th and



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completing the submission by December 16, 2016. HCA will be completely caught up with T-MSIS submissions by the middle of December, and CMS will have Washington data to support the work referenced here.

*d. to what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?*

- The AIM team at HCA has AIM partners in RDA, the division of DSHS providing data on behavioral health services, and DOH. This partnership has facilitated coordination and communication among the agencies, and leveraged substantial expertise in research, reporting, analysis, and measurement across state health agencies.
- HCA has made concurrent investments to build out the decision support capacity of the agency. These investments, in part funded through MMIS, complement the SIM investments and the AIM program. These agency investments include plans to build an enterprise data warehouse. This data warehouse will start with Medicaid data, but will be built with a flexible data architecture that can be expanded to include other data sets over time. The agency has also undertaken a major initiative to upgrade and define its data governance policies and practices, beginning with data sharing and privacy rules. This effort is necessary to fully support and make effective use of the IT, data, and analytic investments.

*e. what support can CMS provide to improve states' access to reliable and timely data?*

- CMS could support state-based innovation and collaborative multi-payer payment models by facilitating more readily accessible and timely Medicare data.
- Gaining access to reliable and timely data must be seen as an ongoing process rather than a one-time investment. Creating the IT infrastructure to link data from the provider level to health care quality and cost measures and ultimately population health and social measures will require phased investments. For this reason we highly support CMS' modular and incremental approach of making well scoped investments that can show value and gain support, and then building on those investments over time.
- Through more readily accessible Medicare data, state Medicaid agencies would be able to provide a broader understanding of the health care experience of Medicaid clients, and also the clinical behavior of providers who serve both Medicaid and Medicare clients. It would also be beneficial for clinical records for Medicare clients to be included in clinical data repositories.

*f. How can CMS support improve access to and linkage with health outcomes measures data*

- CMS should support states in the effort to align payment models and performance measurement through the standardization and simplification of quality performance and health outcomes measurement. CMS should support the development and validation of population-level metrics to facilitate population health outcomes measurement.
- Several challenges of linking to health outcome measure data will include
  - Incorporating population and social outcomes data. This will entail sharing data across entities and potentially extending funding beyond traditional state Medicaid purchasers.

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Sharing data and, at the same time, protecting the privacy and security of clients is a major challenge for states, and has many implications that cross state borders. CMS could take a lead in providing guidance and clarity around this effort.

- Having standard technical definitions of health outcome measures, at least at the state level. CMS could help by providing guidance on developing good technical specifications and improve sharing of information and coordination among state Medicaid agencies.

*g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?*

- Washington has access to a considerable amount of data related to both compliance and program integrity. Washington is in the process of transitioning the compliance and program integrity program from one targeted primarily on a fee for service system to one based on managed care.

*h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?*

The AIM master data management investment at HCA will be used to improve data quality and consistency, and to make it easier to extract, integrate, and aggregate data for analysis and dissemination. This work is foundational to creating an enterprise data warehouse. It includes improving our master person index, our master provider index, linking providers to clinics, and patient attribution. This work will improve the quality and consistency of all our reporting from Medicaid and other data eventually brought into our system.

- HCA is working to ensure cross agency collaboration in the use of these tools access and analyze Medicaid claims data. The goal over time, though, is to leverage these tools for other data sources to promote consistency and efficacy in reporting.
- HCA is also procuring both a conceptual and logical data model for claims data. A requirement of this procurement will be that the model will have the flexibility to be applied to a wide variety of clinical and claims data sources. The data model is a foundational investment that will support the creation of a data environment that can be used link patient care to payment models to broad healthcare, population health, and social outcome measures.
- As the Washington State clinical data repository and mandatory APCD are not yet operational, these projects are still in process.



### SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

CMS is interested in assessing the impact of specific care interventions across states. States would have the option of seeking these supplemental awards, and in return would agree to implement a standardized care intervention in areas CMS and states agree are high priority for rigorous assessment (e.g., care interventions for pediatric populations, physical and behavioral health integration, substance abuse/opioid use treatment, coordinating care for high-risk, high-need beneficiaries) and participate in a robust evaluation design led by CMS. Unlike SIM Round 1 and 2, states would forego the flexibility of varying the intervention, so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.

Many novel care interventions and approaches have emerged nationally, with promising results. The ECHO project and SBIRT are some examples of successful care interventions that started small and then scaled when demonstrated tangible improved health outcomes. While WA has made great progress on the financial integration of physical and behavioral health services, much work needs to be done to fully integrate clinical care for physical and behavioral health care and in other areas as well. Washington would be open to learning from and collaborating with other states on clinical integration standards and reforms, provided there is sufficient flexibility to build upon and leverage current state-based investments.

### QUESTIONS

1. *CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).*
  - The HCA is well-positioned to leverage its role as the largest health care purchaser in the state to drive standardization of care based on best practice recommendations.
  - HCA's intent is to leverage our purchasing power to drive standardization of best practices and alternative payment model adoption statewide. For example, our Care Transformation strategy in our Accountable Care Program includes requirements to submit annual Quality Improvement Plans to detail their progress to implement best practice recommendations produced by the Bree Collaborative. We are working with purchasers throughout the state to spread and scale this model of accountable care, and have developed a Roadmap to more closely align our Apple Health and PEBB programs and accelerate the adoption of value-based payment models.
    - For example, we intend to implement Bree Collaborative requirements into Medicaid contracts.
  - CMS should support states to develop and implement interventions that address the specific needs of their populations by aligning Medicare and Medicaid reimbursement and care delivery policies, and expand the Health Home demonstration into an ongoing program.

## HCA's Response to CMS' Request for Information on State Innovation Model Concepts

2. *Would states be willing to standardize care interventions to align with other states participating in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?*

- As mentioned above, Washington would be willing to learn from and collaborate with other states on care interventions, provided sufficient flexibility is included in any shared model, allowing states to tailor the program to their specific needs and programs. For HCA to commit to engaging in a multi-state intervention in Washington, the intervention(s) would need to align with the transformative work in progress and key strategies in place.
- In particular, standardized care interventions would need to align with Washington's existing Care Transformation strategies and clinical policies.
- Washington strongly supports the appropriate use of randomization, whether it be intra- or inter-state, in any such multi-state intervention.
- Contract timelines vary by Medicaid and our Public Employee program, though both are on annual cycles. Time needed for approval and implementation would likely vary depending on the scope, scale, and target population of the intervention.
- Partnership or input on the design from academic institutions and other research experts would be ideal as expertise should be leveraged.

3. *Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.*

Some key interventions needing additional evidence and detail include the following:

- Clinical integration of physical and behavioral health, particularly primary care into behavioral health settings
- Opioid treatment and guidelines
- In particular, further evaluation of the ECHO model, as applied to addiction and mental health, could facilitate its broader use in other medical and behavioral health scenarios
- Community-paramedicine – proactive care management provided by EMTs to “high-utilizers”
- Community-based nurse care management model for sustained treatment with prescription drug usage (e.g. opioids)
- While promising, behavioral health interventions need more evaluation and development of best-practices.

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4. *CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.*

For various reasons, individuals with mental illness are often excluded from evaluations, but are a critical population to study. This population must be included in the evaluation of any future mental health intervention.

- CMS should strive to more closely align Medicare with state-based Medicaid interventions and programs targeting these vulnerable populations. CMS should prioritize collaborating with states and aligning Medicare and Medicaid to improve the outcomes and health care system experiences of dual eligible beneficiaries.

### SECTION III: STREAMLINED FEDERAL/STATE INTERACTION

CMS seeks input on how to improve both coordination among related federal efforts in support of state-based delivery and payment reform efforts (e.g., workgroups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

#### QUESTIONS

1. *CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?*

Washington State is pleased to be a SIM Round 2 state awardee and is in strong support of continued efforts by CMS and the Innovation Center to partner with states on transformation efforts. We look forward to continued partnership with CMS and the Innovation Center and future collaboration to drive health care payment and delivery system transformation.

- Despite the limited participation in Medicare initiatives, we and many health care stakeholders in our state are fully committed to health care transformation. We believe greater flexibility in the model details would lead to greater participation in Medicare initiatives. Washington State has invested heavily in aligning performance measurement, care transformation principles, and payment strategies, and CMS should allow for the inclusion of state-based policies and programs into future Medicare initiatives. For instance, HCA would have been more likely to apply for CPC+, and encourage our stakeholders to do so, if there were greater flexibility in requirements around quality measures and care transformation.
- Washington State and CMS have rightly recognized the importance of integrating physical and behavioral health in key transformation activities, yet pharmaceuticals have largely been left out of the innovation space. Pharmaceutical costs are a key driver in overall healthcare costs, and

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CMS should consider ways through which to integrate innovations in pharmaceutical payments and policies in future initiatives.

- Finally, investments and savings cannot simply sit within the clinical delivery system. In order to drive sustained population health improvement, CMS should explore innovative approaches to supporting and reinforcing social and community service systems that are essential for population health improvement. Understanding the critical role that social determinants play in population health, CMS should promote and explore innovative strategies and payment models that invest in social services and community supports. Greater flexibility for what services Medicaid dollars can be spent would support such a strategy.

### *2. How can CMS/HHS better align in order to support state delivery system reform efforts?*

We appreciate CMS' willingness to seek input from states, and are encouraged by the opportunity to provide feedback as to how CMS might better align in order to support ongoing, accelerated delivery system transformation.

- HCA is expanding the Medicaid Health Home initiative to better more timely care for patients with complex care needs. A shared savings arrangement, providing returns within the biennial budget cycle, would improve the sustainability and effectiveness of this program. Distributing shared savings within current biennium cycles would support the ongoing success and sustainability of such an arrangement.

There are a few key strategies CMS should consider that would likely accelerate the adoption of value-based payment models and better support state delivery system reforms:

- CMS should provide ample flexibility state awardees to reward providers with grant funds (e.g. bonus payments) for participation/performance.
- CMS should leave room for states to integrate state-based standards and policies into federal initiatives. Such flexibility would allow WA to tailor initiatives to the abundance of groundwork already laid in the state.
- Prior to releasing a new initiative, CMS should consistently give states an opportunity to vet the proposal. At times, certain federal initiatives (e.g. Accountable Health Communities, Transforming Clinical Practice Initiative) have created confusion among Washington stakeholders and friction between ongoing state-led initiatives or come as a surprise with limited time for consideration (e.g. Comprehensive Primary Care Plus).
- For Medicaid/Medicare dual eligible population, CMS should consider requiring that if the MCO of choice also offers a Medicare plan option, the member must choose that Medicare plan. This would provide greater financial stability for programs serving this population and allow for more effective payment model innovation.
- CMS should consider regulatory means of supporting health system transformation, particularly regarding insurance regulation and EHR standardization. While insurance is regulated state-to-state, CMS should consider communicating recommendations for regulation that would support the movement from volume to value. Additionally, EHR interoperability is a critical barrier impeding progress towards population health management and accountability. Standardization would help to alleviate this barrier.

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- CMS should explore funding mechanisms to allow better integration of Community Health Workers into clinical practices, without requiring their certification or barriers to authentic and varied community health work.
- CMS should explore block grants for regional development and customization of total cost of care innovations.
- CMS should explore incentives for participating in practice transformation efforts (e.g. shared resources like behavioral health specialists, Bree Collaborative recommendations, funding for patient decision aides, or regional EHRs);
- CMS should seek alignment and consistent messaging with other federal entities and across initiatives. Communications and expectations should be clear and readily disseminated to a broad audience. Seeking alignment and granting states flexibility in multi-payer efforts will improve our collective chances for successful transformation.

## Appendix A: HCA's Value-based Roadmap

# HCA VALUE-BASED ROAD MAP, 2017-2021

## INTRODUCTION

There is a national imperative led by Medicare, the biggest payer in the U.S., to move away from traditional volume-based healthcare payments to payments based on value. Over the past year this movement has gained significant traction since Medicare declared its own commitment to value and quality, announced its own purchasing goals (similar to HCA), and made substantial progress in meeting its goals. At the same time, federal legislation—the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, supports Medicare’s acceleration of value-based purchasing by rewarding providers through higher Medicare reimbursement rates for participation in advanced value-based payments (VBPs) or Alternative Payment Models (APMs) starting in 2019.

Like Medicare, the Washington State Health Care Authority (HCA) is transforming the way it purchases health care. As directed by the Legislature in statute, and as a key strategy under Healthier Washington, HCA has pledged that 80 percent of HCA provider payments under State-financed health care programs—Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) program—will be linked to quality and value by 2019. HCA’s ultimate goal is that, by 2019, Washington’s annual health care cost growth will be 2 percent less than the national health expenditure trend.

To further align with the Centers for Medicare and Medicaid Services (CMS) payment reform efforts and accelerate the transition to value-based payment, HCA is currently in negotiations with CMS for an 1115 Medicaid transformation waiver. If approved, the waiver presents a unique opportunity to accelerate payment and delivery service reforms and reward regionally-based care redesign approaches that promote clinical and community linkages through State-purchased programs. Moreover, if the waiver is approved, HCA commits that 90 percent of its provider payments under state-financed health care will be linked to quality and value by 2021.

## PURPOSE AND GOALS

The HCA Value-based Road Map lays out how HCA will fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. This HCA VBP Road Map braids together major components of Healthier Washington (Payment Redesign Model Tests, Statewide Common Measure Set and Accountable Communities of Health (ACHs), for example), the Medicaid transformation waiver, and the Bree Collaborative care transformation recommendations and bundled payment models. The Road Map is built on the following principles:

- Reward the delivery of patient-centered, high value care and increased quality improvement;
- Reward performance of HCA's Medicaid and PEBB Program health plans and their contracted health systems;
- Align payment and delivery reform approaches with CMS for greatest impact and to simplify implementation for providers;
- Improve outcomes for patients and populations;
- Drive standardization based on evidence;
- Increase long-term financial sustainability of state health programs; and
- Continually strive for the Triple Aim of better care, smarter spending and healthier people.

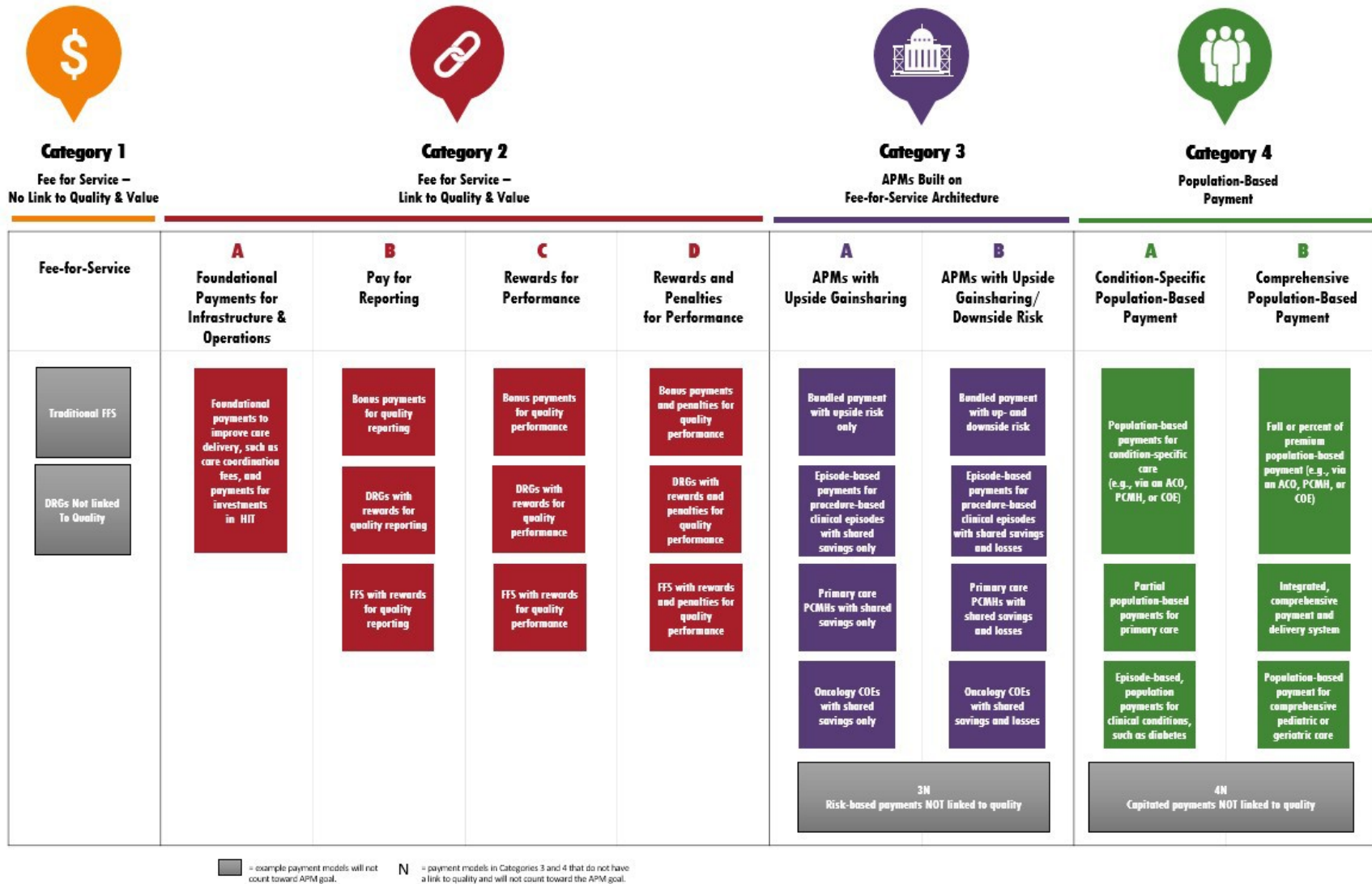
## HCA'S FRAMEWORK AND PURCHASING GOALS

As the largest purchaser in Washington State, HCA purchases care for over 2.2 million Washingtonians through AppleHealth and PEBB. Annually, HCA spends 10 billion dollars between the two programs. As a purchaser and state agency, HCA has market power to drive transformation using different levers and relationships.

As stated in the HCA Paying for Value survey released in March 2016, HCA has adopted the framework created by CMS to define VBPs, or APMs (see Chart 1, next page).

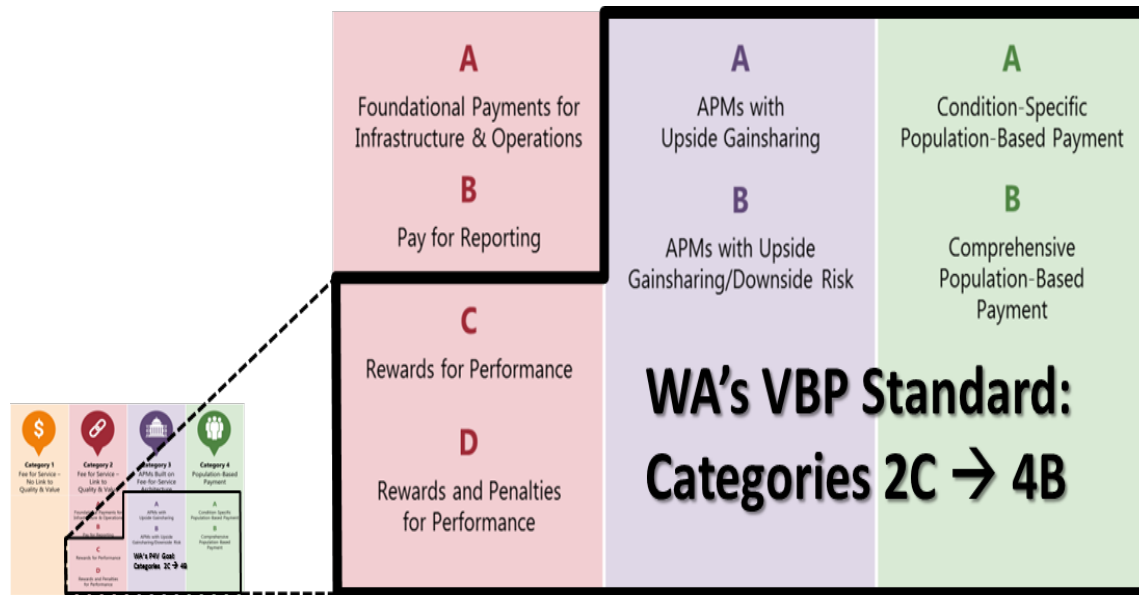


Chart 1: CMS Framework for Value-based Payments or Alternative Payment Models



HCA's implementation of the CMS framework is shown below in Chart 2.

**Chart 2: Washington State's Value-based Payment Framework**



To reach its purchasing goal, HCA expects 90 percent of state-financed healthcare payments to providers will be in CMS' categories 2c-4b by 2021. HCA's ultimate vision for 2021 is:

- ☐ HCA programs implement VBPs according to an aligned purchasing philosophy.
- ☐ Nearly 100% of HCA's purchasing business is entrusted to accountable delivery system networks and plan partners.
- ☐ HCA exercises significant oversight and quality assurance over its contracting partners and implements corrective action as necessary.

HCA's interim purchasing goals and key VBP milestones along the path to 90 percent in 2021 are shown below.

- 2016: 20% in VBP
- 2017: 30%
- 2018: 50%
- 2019: 80%
- 2020: 85%
- 2021: 90%

## APPENDIX

# CHANGES TO APPLE HEALTH CONTRACTS STARTING IN 2017

This document reflects specific, imminent changes pertaining to the Apple Health program, in alignment with HCA's VBP Roadmap. This document is not all-inclusive of expected long-term changes to the Apple Health program.

Consistent with HCA's VBP targets, there will be significant changes to Apple Health contracts starting in January 2017. MCO contracts will require that a growing portion of premiums be used to fund direct provider incentives tied to attainment of quality. To ensure quality and performance thresholds are being met, HCA will withhold an increasing percentage of plan premiums, to be returned based on achieving a core subset of metrics from the statewide common measure set. HCA will use the same measures in all provider VBP arrangements.

In addition, through use of time-limited funding under the Medicaid transformation waiver, MCOs will be able to earn financial incentives for achieving annual VBP targets (described further in the visual below). In 2018 and each year thereafter, the MCOs' accountability for each of these new contract components will grow progressively.

Finally, the Apple Health program changes include the creation of a "challenge pool" to reward exceptional managed care performance and a "reinvestment pool" to provide similar regional incentives for exceptional performance attributable to the broader participants in an ACH<sup>1</sup>.

A description of the approaches as well as the parties to each approach is described in further detail below. A visual summary of funds flow and a table that provides additional detail on how the new incentive structures would work are included at the end of this document.

## APPROACHES

### TIME-LIMITED INCENTIVES FOR MCOs AND ACHs

#### *HCA-MCO AND HCA-ACH*

MCOs will earn incentives funded through Initiative 1 of the Medicaid transformation waiver for exceeding VBP target thresholds, starting with 30 percent in 2017. These incentives will be in place for the five years of the waiver, but will not extend beyond the waiver period. Performance will be measured consistent with the approach taken in HCA's Paying for Value RFI, by looking at the

<sup>1</sup>This document refers to the ACH role broadly, recognizing ACH participants include MCOs and providers, for which specific roles are also highlighted.

proportion of payments tied to value-based arrangements (as defined in the HCP-LAN framework). Through the waiver, ACHs will also be able to structure incentive programs regionally to reward providers who are undertaking new VBP arrangements, these will be tied to the same VBP targets.

## PROVIDER INCENTIVES UNDER MANAGED CARE

### *MCO-PROVIDER*

Value-based payment strategies require risk sharing and other financial arrangements between providers and plans that reward value outside of a fee-for-service model. To ensure that providers are being adequately incentivized in these arrangements, HCA will establish a percentage of premium threshold that each MCO must meet as part of its contractual obligations. Beginning in 2017, MCOs must ensure that at least 0.75 percent of their premiums going to providers in the form of incentives that help ensure that value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.

## QUALITY WITHHOLD

### *HCA-MCO*

HCA will withhold a progressively increasing percentage of premiums paid to MCOs on the basis of quality improvement and patient experience measures. MCOs will need to demonstrate quality improvement against standard set of metrics to earn back the withheld premium amount. Today, HCA utilizes a 1 percent withhold related to the quality of data submissions from MCOs to HCA. This approach broadens the quality standards being measured and increases the percentage of withhold gradually each year, until it reaches 3 percent in 2021.

## COMMON MEASURES

### *HCA-MCO-ACH-PROVIDERS*

HCA has committed to using standard measures of performance across its purchasing activity, consistent with the statewide common measure set. In addition, these measures will drive the evaluation and incentive payments under the Medicaid transformation waiver. Specifically, HCA anticipates a core subset of common measures to be used in its contracts with MCOs around the quality withhold and also expects to see this same core set of measures used in VBP arrangements between plans and providers. A good example of how the common measure set is already being used in HCA purchasing efforts can be found [here](#).

## CHALLENGE POOL

### *HCA-MCO*

Washington State has embraced the value of a competitive managed care model for delivering Medicaid services. HCA's approach to VBP seeks to reward exceptional performance of MCOs through use of a "challenge pool." Unearned VBP incentives from the waiver and uncollected withhold payments from managed care premiums will be made available in a challenge pool that rewards plans that meet an exceptional standard of quality and patient experience, based on a core subset of measures.

## REINVESTMENT POOL

### *HCA-MCO-ACH-PROVIDERS*

The value-based payment structure for Medicaid also provides a reinvestment pool, funded similarly to the "challenge pool," which would use unearned ACH VBP incentives and a share of unearned MCO incentives to provide meaningful reinvestment in regional health transformation activities, based on performance against a core subset of measures. This provides a continuing incentive for multi-sector contributions to health transformation and rewards the delivery system and supporting organizations for achieving quality and improved patient experience.

## VALIDATING VBP ATTAINMENT IN MANAGED CARE PROVIDER CONTRACTING

To adequately measure the status of payer-provider arrangements under Medicaid that are proprietary in nature, HCA will use a third-party assessment organization to review and validate detailed plan submissions. A similar model is used today through the federally required External Quality Review Organization that provides annual reports on the performance of each MCO.

## SUMMARY

Taken together, these components reflect a phased incentive approach that emphasizes more equal weight being placed on ACHs and statewide managed care organizations (payer and provider networks) in achieving the state's roadmap to value-based payment over the next five years. They also show how contractual and financial levers are used to sustain community reinvestment and sustainable incentive structures that can last well beyond the waiver. This approach ensures mutual accountability for the performance of the health system in service of whole-person health outcomes and quality improvement.

## Apple Health Value Based Payment - Overview and Sample Scenario

CALENDAR YEAR	VBP INCENTIVES			MANAGED CARE ORGANIZATION (MCO) INCENTIVES		CHALLENGE POOL	REINVESTMENT POOL
	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)	STATE VBP Target	Managed Care Organization (MCO specific)	Managed Care Organization (MCO specific)	Managed Care Organization (MCO specific)	Accountable Communities of Health (ACH Specific)
	VBP Target Incentive <sup>1</sup>  % of each incremental % point of premium over/under VBP	Region Specific VBP Target Incentive <sup>1</sup>  \$ tied to each 1% over State VBP Target <sup>2</sup>		Provider Incentives  % premium for provider quality incentives	Quality Withhold  % premium at Risk for performance <sup>3</sup>	Unearned VBP Incentives <sup>4*</sup>  % of unearned MCO Incentives and withhold	Unearned ACH VBP Incentives <sup>4*</sup>  % of unearned ACH VBP and a share of unearned MCO incentives
Pre	-	-	20%	-	-	-	-
2017	(+/-) 2%	\$200k for each 1%	30%	0.75%	1.0%	(up to) 1%	
2018	(+/-) 1.5%	\$300k for each 1%	50%	1.0%	1.5%	(up to) 1%	
2019	(+/-) 1%	\$666k for each 1%	75%	1.5%	2.0%	(up to) 1%	
2020	(+/-) 0.75%	\$1m for each 1%	85%	2.0%	2.5%	(up to) 1%	

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HCA Value-based Road Map, 2017-2021

<b>2021</b>	(+/-) 0.5%	\$1.2m for each 1%	90%	2.5%	3.0%	(up to) 1%	
<i>Post</i>	Not extended beyond the five year waiver period		90%+	3.0%	2.5%	0.25% + 25% of remaining withhold <sup>1</sup>	0.25% + 75% of remaining withhold <sup>1</sup>



SAMPLE SCENARIO							
<b>2017</b>	<p>MCO "A" with \$1B of premiums exceeds VBP target statewide by 20% in year 1 and earns \$4M.</p> <p>MCO "B" with \$1B of premiums is short in meeting the VBP targets statewide by 10% in year 1 and pays \$2M out of its premium withhold.</p>	<p>ACH "A" exceeds VBP regional target by 10% in year 1 and earns \$2M of DSRIP incentive.</p> <p>ACH "B" is short in meeting the VBP regional target by 10% in year 1 and does not earn a DSRIP incentive.</p>	30%	<p>MCO "A" is contractually obligated to allocate at least 0.75% of its premium to providers in the form of incentives that help ensure value-based arrangements are adequately rewarding and incentivizing providers to achieve quality and improved patient experience.</p>	<p>MCO "A" demonstrates quality improvement against common measures and earns back 1% withheld premium amount.</p> <p>To earn back the 1% premium withhold, MCO "A" must also achieve the state VBP target and pass at least the required % premium for provider quality incentives.</p>	<p>MCO "A" exceeds quality improvement target by 5 basis points— earns back complete premium withhold and is eligible for challenge pool, not to exceed 1% of premium.</p>	<p>ACH "A" meets quality improvement target and is now eligible for its share of the reinvestment pool.</p>



<sup>1</sup> Challenge and reinvestment pools funded by unearned MCO VBP incentives and ACH VBP incentives (under DSRIP) as well as any unpaid premium withhold for quality

<sup>2</sup> Not to exceed 1% of managed care organization's total premium payment, with a \$20m annual aggregate maximum across all MCO VBP Incentives

\*Notto exceed \$7.5M for any region in any year, with a \$20M annual aggregate maximum across all ACH VBP incentives

\* Or 75% of year to year trend increase (averaged across eligibility groups), whichever is lower, but not below 1%

\*Dollars accrued for reinvestment and challenge pools are split equally between MCO and ACHs.

\*Total combined value of challenge and reinvestment pools will not exceed \$25M on an annualized basis.

\*Postwaiver period, challenge pool is composed of 0.25% of all MCO premiums and 25% of any unearned withhold - the reinvestment pool is funded similarly with 75% of remaining withhold.

Example for MCO "A" 2017

Experience	Calculation	Result
Total premium		1,000,000,000
Quality improvement withhold	1% of premium	(10,000,000)
Achieves 50% VBP vs. 30% target	2% incentive x 20% excess x \$1B premium	4,000,000
Amount for provider incentives	0.75% of premium	(7,500,000)
Demonstrates quality improvement	1% of premium	10,000,000
Meets exceptional performance standard	Up to 1% of premium, depending on amount in pool	<u>5,000,000</u>
Total premium plus incentives		1,001,500,000



**From:** [Cook, Jennifer A](#)  
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**Cc:** [Scholz, Thomas](#); [Willard, Jean C \(UI Health Care\)](#); [Dorsey, Kathryn K \(UI Health Care\)](#); [Jones, Cheryl](#)  
**Subject:** RFI  
**Date:** Friday, October 28, 2016 4:30:35 PM

See below for comments from the University of Iowa Division of Child and Community Health in response to the State Innovative Models Initiative Request for Information.

Transitioning providers toward advanced alternative payment models through multi-payer delivery and payment reforms could provide incentives that benefit overall population health. However additional resources, tools and support for the development of activities and measures that provide a robust path toward population-based improvements in child health and development activities would benefit these efforts. The focus on Medicare delivery systems has great potential for cost savings, quality improvements, and population health advances. However, potential for long term impacts begin many years before most Americans become eligible for Medicare coverage. Pediatric Value-based payment models have potential to generate improvements in population health, health transformation, and cost savings through mechanisms that are distinct from adult-based models. For example, practices caring for Children with Medical Complexity could be provided with performance incentive bonuses and risk-adjusted PMPM payments to cover expenses from providing family support and care coordination to families. However, risk adjustments need to account not only for pediatric-specific medical complexity but also for social complexities associated with social determinants of both long- and short- term health outcomes. Pediatric health improvement activities, based on evidence-based or innovative evidence-informed strategies, should account for the unique needs of children's development, physiology and family structure.

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