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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.¹ 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

¹"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,



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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.² 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,

² “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.

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.³ 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

³ "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.

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.⁴ 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.

⁴ 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 to tie 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.⁵ 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.

⁵ "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.

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).⁶ 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

⁶ "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.

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.⁷ It has been successful due to the level of

⁷ "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.

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.