December 16, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

NAMD Comments on Final Rule with Comment: ***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-FC)**

Dear Acting Administrator Slavitt:

On behalf of the nation's Medicaid Directors, thank you for the opportunity to comment on the Final Rule with Comment Period, *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-FC).

The National Association of Medicaid Directors (NAMD) is a bi-partisan, non-profit organization that represents Medicaid Directors in all 50 states, District of Columbia and the territories. Medicaid Directors are leading the movement to transform the health care delivery system from volume to value, especially for the nation's most vulnerable and complex populations. State-led alternative payment models (APMs) are beginning to reverse the trajectory of health care cost growth,[1] and in many states, these models are being deployed across multiple payers.

We applaud CMS's willingness to consider further comment on areas of the Advanced APM program that intersect with Medicaid value-based purchasing. We also appreciate CMS's engagement with states on MACRA implementation to date. Thoughtfully addressing the multi-payer aspects of the program – and reflecting unique Medicaid considerations – will be critical to the success of our collective work to improve health outcomes and contain costs.

In particular, Medicaid Directors caution that the multi-payer component of the Advanced APM program is complex. It will take time to fully understand the implications of the policy on Medicaid APMs and the Medicaid delivery system. Regular and ongoing engagement with states

[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.

will be needed to identify any major policy concerns, as well as technical implementation issues that are likely to emerge. For instance, it is unclear if financial risk in Medicare might result in the delivery system looking to Medicaid to prevent hospital/clinician closure when providers are impacted by downside risk. **We continue to urge CMS to work with Medicaid leaders as a regular part of the implementation of MACRA to address such potential policy and implementation issues.**

In the sections that follow, we provide further input on ways that CMS can address unique Medicaid considerations in the All Payer Option of the Advanced APM program. This input responds to key requests for comment in the final rule and builds on our previous response to the NPRM. Our comments are divided into four sections: 1) the process for identifying Medicaid Advanced APMs; 2) a state-specific Alternative Pathway; 3) financial risk requirements, and 4) the intersection of the Advanced APM program with existing multi-payer innovation.

Process for Identifying Medicaid Advanced APMs

We continue to underscore the need for a streamlined process to identify Medicaid models that are considered Other Payer Advanced APMs, including APMs implemented through managed care. This process should minimize the administrative burden on states and provide a "no wrong door" for states to bring models to CMS for certification. These objectives can be advanced in the following ways:

- *The initial process for certifying Medicaid Advanced APMs should be based on information already available to CMMI and CMCS to the degree possible.* This might include information available under State Innovation Model (SIM) grants, Comprehensive Primary Care Plus (CPC+) program, Medicaid waivers, state plan amendments (SPAs), and contract approvals. States should be permitted to review the certification before it is finalized and provide additional information to inform it, as appropriate. This process will reduce the administrative burden on states, while ensuring the accuracy of Advanced APM certification determinations.

- *CMS should begin identifying qualifying Medicaid Advanced APMs as soon as possible.* It will be important for CMS to provide clear direction on models that are certified as Advanced APMs well in advance of the first performance year for the All-Payer Option. This will be necessary to support the state and provider planning processes. It will also be vital to the delivery system transformation and provider infrastructure required for successful participation in Advanced APMs.

- *The process for certifying new Medicaid Advanced APMs should be integrated as seamlessly as possible into the design of new models, as well as into the review of Medicaid waivers and SPAs.* For instance, if a proposed 1115 waiver includes an APM, that APM could be certified as part of the waiver approval process. More importantly, CMCS and CMMI decision-makers should be at the table together in initial state and CMS discussions on potential Medicaid Advanced APM components. This joint involvement should occur before ideas are

included in waivers and/or SPAs. This will help to ensure that the certification of Medicaid Advanced APMs does not delay timely approval of SPAs and waivers, and ultimately this will create a more effective and integrated process for Advanced APM certification.

- *There must be a well-defined pathway for APMs implemented through managed care organizations (MCOs) to be certified as Advanced APMs.* Many state Medicaid programs are requiring MCOs to implement APMs but are directing MCOs to design the specific APMs to meet the needs of the community. States monitor these models using various methods, including prospective and retrospective approaches. CMS's process to identify Advanced APMs in managed care must account for this variation and minimize additional burden on states and MCOs. Failure to create this clear pathway for APMs in managed care will, at a minimum, generate confusion about the qualification of a particular model(s) as a Medicaid Advanced APM. But perhaps more troubling, it could also result in the allocation of resources to models intended to, but that fail to quality as Advanced APMs. This could discourage investment and participation in more forward-leaning or innovative value-based payment models in states that primarily use a managed care delivery system.

Alternative Pathway for State-Specific Models

As we discussed in our initial comments, an Alternative Pathway should be created in this program that allows state-specific models to be certified as Advanced APMs under the All Payer Option. State Medicaid programs and providers are at different points along a continuum towards the objectives of CEHRT use, payment linked to quality measures, and bearing financial risk. States are pursuing these principles in a manner that reflects the local health care marketplace, the provider landscape, and the needs of beneficiaries. An Alternative Pathway for state-specific models can advance the goals of alignment, while recognizing the fundamental variation among states and Medicaid programs.

Should CMS further specify this alternative pathway, at a minimum, we encourage CMS to consider the following:

- *In the Alternative Pathway, allow states to select one of two options for financial risk: states could demonstrate the level of risk that is nominal or more than nominal (within a permitted range) OR choose from a menu of CMS-defined methods for calculating/determining the level of risk.* The financial risk element of the Advanced APM framework is one of the most complex components of this program. As we noted in our initial comments, there are merits and challenges in setting a single threshold for risk in Medicaid APMs that qualify as Advanced APMs. In some states, a federally-set threshold for risk might create important levers and supports to move forward with risk-based models. However, in other states, a single threshold could discourage the adoption of Medicaid Advanced APMs. For example:

    - State Medicaid programs have different levels of reimbursement and spending growth across provider types and patient populations. A fixed level of risk, (i.e., 4 percent) could

stunt the adoption of Medicaid Advanced APMs in states with lower reimbursement and spending growth levels by dissuading participation among providers with thinner Medicaid margins.

- Medicaid providers serve a very complex, high-cost population. A federally-set risk percentage does not account for unforeseen cost fluctuations or catastrophic cases that are unique to Medicaid providers. This may be especially problematic for small or multi-specialty clinical operations, which generally cannot take on the same level or type of financial risk as larger providers.

As we have noted before, this complexity – and the merits and challenges of a single risk threshold – can be navigated through the alternative pathway for Medicaid Advanced APMs. While the federally-defined risk threshold would apply in the standard Advanced APM criteria, the alternative pathway could provide two options for state Medicaid flexibility around financial risk. First, it could permit states to demonstrate the amount of risk that is "nominal" (in the case of a Medicaid medical home) or "more than nominal" (for all other Medicaid APMs), within a permitted range. Second, states could instead select from a CMS-created menu of methodologies to calculate and determine what is nominal or more than nominal financial risk. Allowing states to use one of these two options in the Alternative Pathway would better recognize unique Medicaid considerations discussed above, while ensuring broad consistency with the Advanced APM construct.

- *Allow states to demonstrate an appropriate threshold and/or phased-in process for EHR use when models include LTSS, behavioral health, and/or small, rural providers.* Medicaid Directors agree with the importance of leveraging electronic health records (EHR) and clinical data to improve the coordination of care and outcomes through APMs. Many Medicaid programs are actively seeking to enhance its use as a central tenet of APMs. However, EHR uptake among key Medicaid providers, such as behavioral health, LTSS and rural providers, has been slow – largely due to their exclusion from the EHR incentive program and fewer resources to implement this technology. While states are using creative ways to support the adoption of EHRs among these providers, the Alternative Pathway should recognize this issue and allow states to set an appropriate threshold and/or a phased-in strategy for EHR use in the model. This approach is important as performance measurement in APMs will depend on analytic tools applied to datasets that are both reliable and comprehensive.

- *Allow states to develop and certify as Medicaid Advanced APMs those models that are focused on outcomes for specific sub-populations.* The needs and health status of Medicaid sub-populations (i.e., adults with serious mental illness, children with complex conditions, etc.) vary among and within states. Such variation has resulted in a range of state-led and locally-engaged solutions that reflect the diverse and culturally dynamic community environments in which Medicaid members live. State-specific models targeting specific sub-populations will be able to leverage existing experience and capability in provider networks and local communities. In addition, flexibility in identifying the APM subpopulation (e.g., family-centered vs. individual

member-focused) may enable unique multi-payer demonstrations that incentivize broad provider delivery system enhancements, promote integrated care, and align outcome measures across different payer populations.

Financial Risk

States broadly agree with the objective of incorporating shared financial risk into APMs. But as discussed above, Medicaid Directors continue to underscore that the risk component is one of the most complex and critical aspects of the Advanced APM program, especially in Medicaid where providers may have differing capacities to bear financial risk. Special consideration should be given to this component throughout the implementation process and in CMS's engagement with states. In addition, CMS can navigate this complexity and unique Medicaid considerations by creating the Alternative Pathway for Medicaid Advanced APMs, as outlined above.

In addition to the Alternative Pathway, we respectfully request CMS make the following specific changes to the risk requirements that apply to Medicaid Advanced APMs. These changes are needed to ensure the Advanced APM program promotes, rather than discourages, broad alignment with Medicaid payment reform:

- *CMS should more clearly define its concept of financial risk in the Advanced APM program and harmonize it with widely-accepted APM frameworks.* States are concerned that the current regulations do not provide sufficient clarity around the concept of financial risk. For example, there appears to be dissonance between the designation of "nominal risk" in the CPC+ program with HHS' Learning and Action Network's Framework for APMs. In addition, states continue to express concern that the risk construct is broadly geared towards ACOs and other large providers, and does not account for clinicians that serve a small population, such as multi-specialty, single-specialty or rural/frontier providers. We request that CMS more clearly address these providers in its financial risk concept going forward, recognizing they are not positioned to bear "insurance risk" in the same way as certain large provider entities. Ultimately, we encourage CMS to ensure financial risk is conceptualized in a way that will transform clinical decision-making for all providers (large and small, rural and urban) to manage the patient journey and not just the short-term clinical service.

- *The level of risk that applies to Other Payer Advanced APMs should not be more complex or more significant than the level of risk applied to Medicare Advanced APMs.* We are concerned that the Other Payer Advanced APM program makes the risk requirement more complex for Medicaid models than for Medicare models by including marginal risk and minimum loss rate requirements. CMS acknowledged the overly-complex nature of these elements when removing them from the Medicare framework. Maintaining these additional criteria for Medicaid APMs would likely discourage alignment across payers, which is a key objective of this new Medicare payment program.

  We recognize CMS's concern that it does not want other models to "game the system" by incorporating less meaningful risk requirements. However, state Medicaid programs are

unlike other payers. States are co-financers of the Medicaid program – in partnership with CMS – and have a vested interest in ensuring APMs are appropriate and robust. States should be viewed as partners in the administration of the Medicaid component of the Advanced APM program. Therefore, rather than create overly prescriptive risk requirements for Medicaid Advanced APMs, CMS should use existing processes to work with states on the effective design and deployment of APMs.

- *A revenue-based risk standard should be permitted for Medicaid Advanced APMs.* While most population-based payment models in Medicaid are based on expected expenditure benchmarks, states should not be precluded from using a revenue-based benchmark for risk. At a minimum, Medicaid programs should have the option to use this alternative risk benchmark that will be available for Medicare APMs. This type of benchmark may become an increasingly important option as more payers, including Medicaid, incorporate financial risk for small and rural providers.

Intersection with Existing CMMI & State Multi-Payer Initiatives

We are concerned that the final regulation does not articulate how existing federally-led, multi-payer models intersect with the All Payer component of the Advanced APM program. As we have noted in previous comments, many states are engaged in multi-year, resource-intensive efforts with CMMI to implement APMs, including SIM grants and the CPC+ program. We are concerned that the lack of linkage between these efforts may disrupt the successful work to date. Medicaid Directors urge CMS to ensure the Advanced APM program builds on and complements the work many states have underway to promote multi-payer alignment around APMs. This can be achieved by permitting state-led, multi-payer APMs under SIM or CPC+ to be considered Advanced APMs, or at a minimum, by articulating how SIM and CPC+ intersects with the Advanced APM program.

Once again, we appreciate the opportunity to comment on this final regulation and applaud CMS for giving attention to the important Medicaid implications of the Advanced APM program. We look forward to ongoing engagement with you and your team as you implement this program and as we work towards the shared goal of value-based health care.

Sincerely,

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